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SHREVEPORT, LA.

According to custom, the Louisiana State Medical Society holds an annual public meeting at some time during its scientific assemblage each year, and it is for this purpose that we have assembled this evening. According to custom again, the retiring President of the Association is expected to deliver an annual address: he is expected to submit for your entertainment somewhat of a resumé of the accomplishments of the medical profession in the past, or picture for your mind's eye, her program of scientific activities for the future.

According to this custom, I would be excused were I to go back to the era of Mythology when Aesculapius came to earth, and bring you on down the ages of Pythagorus, Hippocrates and Galen. Again I might be permitted to discuss with you, the achievments of men of a later age, Harvey, Pasteur, Lister, Koch, Roentgen and other masters who have made modern medicine possible. Yes, according to custom, I might tell you of the things being accomplished today and the problems which are at this moment, unfolding before our very eyes, because of the labors of men who are now living and working, some of whom no doubt, are sitting in this very audience.

But, my friends, custom is akin to tradition; it is a static condition or process and cannot serve as our only guide in a moving changing age such as the present. There certainly can be no one with a mite of intelligence who would question the statement that medical science has brought her share of happiness, prosperity and contentment to mankind. And judged by her past, there certainly can be no one who doubts that she will meet successfully, the scientific problems confronting her today and that will certainly arise in the future.

And so, contrary to custom, I dare this evening to leave behind those things known and obvious to us all and ask your attention for a brief few minutes, to that phase of our work which it seems so few realize, is the very foundation upon which rests future progress in medicine.

Judged by history, it would appear that we need have no fear for the future of scientific medicine so long as the medical profession is permitted to direct her destiny. Judged by history again, we need only to glance at those countries that have taken the fatal course of endorsing outside interference in medical matters, to be convinced of the need of concerted and organized opposition to such schemes.

My friends, outside of the profession, we are appealing to you to come to the rescue of one of America's greatest institutions. The physicians present this evening will tell you that the practice of medicine in this country is distinctive. The individuality, the personal incentive and ambition, qualities which have made our country great, must be preserved not only in medicine, but in all of her institutions. The great question confronting the American

*President's address, delivered at the meeting of the Louisiana State Medical Society, New Orleans, May 9, 1932.

medical profession today, and more particularly the American people, is whether the medical profession shall continue to operate with the individual doctor as a human unit, spurred on by individuality, ambition and incentive, or shall it be operated as a cold blooded piece of machinery, with the individual doctor as a mere cog in the wheel. The former is an American ideal and has resulted in great achievement; the latter is foreign to our very nature and has brought despair, discontent and a degenerated service in those countries that have tried it.

In this country under our present system, the scientific level of the individual doctor determines the scientific level of the whole profession, and it is the paramount duty of Organized Medicine, as well as society, to see that no unjust barriers be permitted to lower that level. We know of no machinery which will provide ways and means for maintaining the individual doctor at a high standard of scientific development and equipment, excepting the efforts of the doctor himself. Unless these efforts succeed, the individual deteriorates and when he deteriorates, the whole profession deteriorates while the public suffers. That these efforts are failing, no one who has given the subject thought, will deny, and why they are failing, the profession well knows and the public would like to know.

The medical profession knows and the masses of the profession who are feeling the pressure, would like for the public to know that their sources of income are being unconstitutionally, unfairly, unjustly and without reason, taken from them by the Government, its subdivisions and misguided organizations.

The primary object of the medical profession is to render service to suffering humanity, but they must be paid for this service as it is their only means of livelihood. The medical profession stands ready and willing to render medical service free to all the indigent of this country, and is only asking that those able to pay be required to do so, and that their names be erased from the Government and reckless charity organizations. It is unnecessary to go into particulars. The general accusation that the National Government, the various states, subdivisions and municipalities have and are adopting as a policy the provision of medical care and service for those well able to provide for themselves at the expense of the general tax fund, stands unchallenged. That various private and public organizations, supposedly operating for the indigent, are commanding the services of the profession for those not deserving, is well known to all.

The high cost of medical care, if any exists, is being forced on those who pay and are partly able to pay, by those agencies which make it possible for those to escape who should pay for their medical service. The American medical profession has never asked and never will ask for legislation or the public moral support of any scheme simply to enrich the doctor, but we do ask the moral support of an enlightened public opinion in the suppression of all schemes and legislation which set aside the doctor as a class to carry heavier burdens than the rest of our citizens. We have an abiding faith in the fairness of American public opinion, and we realize that we have not done our part or duty in getting to the public, facts on which the public could form a correct and fair opinion.

In every community over the country, organizations have been formed and are still forming for the care of those in need. The doctor, like all good citizens, contributes to the support of these organizations, but we have failed to call your attention to the common unfair custom of demanding his service gratis, in addition, when medical service is needed. We have failed to show you that it would be just as fair to demand free clothes and food from your local merchants after they have contributed to your organization, financially. We have failed to call your attention to the fact that many applying for free medical service have only this one need, all other necessi-

ties, and in many instances, luxuries seem to be at hand. We have failed to tell you that when a disaster strikes a given section, that wonderful organization, the Red Cross, is immediately on hand purchasing with cash from her funds, the various supplies needed and dispensed by a paid personnel. But, should illness develop among the stricken, the local doctor with Red Cross button on his lapel, is called to meet this need. We have failed to tell you that the State of Louisiana runs her Charity Hospital with no pay staffs, and is throwing the doors of these institutions wide open to people who have no claims on the charity of the community.

We have not told you that at every session of the Legislature the State Medical Society maintains at our expense a large committee at Baton Rouge to be on the alert and oppose legislation inimical to the health of the people as a whole. We have not brought to your attention, in a systematic way, the pernicious tendencies of our National Congress in legislative matters which are heaping burdens upon your shoulders, pauperizing the medical profession and debasing themselves in the eyes of all who believe in the fundamental principles of our Government.

Yes, my lay friends, these are but illustrations, and the medical profession has faith and confidence in your verdict when you realize the truth.

"The mills of the gods grind slowly." May the protests of the few, arouse our organizations, state and national, from their lethargy and develop some concerted, systematic program of worth to themselves and the nation.

To those members of the medical profession present, I can tell you nothing that you do not already know, but knowledge without action is fruitless. Annually we meet and discuss our scientific problems and adjourn to meet again. In the interim, what are we doing in our organized way? We publish a journal monthly and it reaches just half the doctors of the state, our members. Our national organization publishes a journal and it reaches hardly one third of the doctors in this country. Have we or they any organized plan to contact those without the organizations? Have we anything worth while to those doctors not members of our organization? And do we not realize our need of their help? To refuse or make no effort to preach to others than his closed congregation, would seem a poor and short-sighted preacher.

And again, what do we find within the pages of our state and national journals? Food in plenty, I grant you and of the best for nutrition scientifically, but is this a balanced diet and are there not other functions to be performed by our organizations that are being neglected? What is the American Medical Association or the Louisiana State Medical Society doing in an organized and systematic way to further the interests of the individual doctor and every doctor, that will place him in position to better serve the profession and the public? In answer I will say, "Practically nothing."

What have we in Louisiana been doing to convince those doctors not in our fold, that our organization is worth while, and what have we done that will prove our organization is worth while? We have simply been preaching to ourselves that we are all right and wondering why the other half cannot see it. As a mother organization, I ask again, what has the American Medical Association been doing in proposing, suggesting or planning any program of activity in conjunction with the state societies, to further the whole interests of the whole profession?

Is it not apparent to all who have given the matter any thought, that the medical profession is a stranger to the public? And is there any man so simple of mind as to believe that the American public would do other than to embrace the profession sympathetically and take action positively, if they truly understood our problems, as theirs?

To my mind, my friends, the one big question confronting Organized Medicine today, is the problem of winning to our side, public opinion. It is our fault that we are

without its influence. We have tried to make traditional practices fit and operate in a changed environment. Even the Church operates today, a most business-like machinery, adapting itself to modern methods, recognizing that greater and better service can be rendered in this way.

A great philosopher once said, "It is the duty of every man to so conduct himself and the business in which he is engaged, in such manner that it will increase in scope and become more useful to society in the future." The practice of medicine is our business. Are we conducting it in such manner that it will be of greater service to mankind in the future? If not, where and how are we failing? Certainly, we have not failed scientifically, but have we not failed in not laying a foundation upon which we may stand assured that we can proceed without interference in the future? Working in an atmosphere of mysteriousness, without sincerity to one's self, subsisting upon the plaudits of those who would flatter and impose, drawing aside as different in human nature from our fellow man, allowing things to take their course, the public has become suspicious and unsympathetic, and is listening to the schemes of those who are striking at our very existance.

The medical profession as an organization and individually must come forward unabashed and with firmness, tell the world that in order to carry on, it must be operated on a business basis as far as is practical and posssible. It must come forward and show the world that this can be done to a satisfactory extent with no hardships on anyone, by simply removing from national, state and private organizations, those who have no claim on charity. The medical profession can well afford to provide free medical service to all of those who deserve it, if those who do not deserve it, were taken from the charity lists of our national, state and private organizations.

The individual doctor and individual patient alwys have been able to adjust their business affairs satisfactorily as a rule, and always will be, because the profession has never placed a fixed unvarying price on its service, and has been permitted to serve all of the sick. But under conditions which have gradually developed, resulting in 71 per cent of the sick being cared for as charity or semi-charity, including a large group who have no right to free medical service, it is becoming difficult for the doctor to operate as he should. The critic out there will say, "Well, what are you going to do about it?" My answer is: "I can do nothing, but he and I and you can." By he, you and me, I mean our National Association, our State Association and our local Associations and individual doctors working together, with some semblance of a coordinated plan and aim.

Working on the premise which no one questions as true, that public opinion is invincible, I would urge a program of telling the story to the public. I would urge that this program be initiated by the American Medical Association in a way that each State Association and in turn, the individual component associations, be allotted a definite part and a definite scheme for putting same into action. One year ago, the Bureau of Medical Economics of the American Medical Association was established and they have proposed twenty-nine phases of the subject for investigation. It would seem to one who has given the matter just superficial thought, a most natural function of this Bureau would be to provide a systematic flow of information to the public and our law-makers, on conditions developing that are detrimental to Organized Medicine. Yet, we do not find such an activity listed with the other twenty-nine.

To tell the doctors through the columns of the American Medical Association Journal that a medical education costs so much, that the doctor averages a collection of so much, that medical fees are not burdensome to those who budget their income, is not solving our problems. The average doctor knows now, in a general way, what all these investigations will reveal. Tell it to the people, to Congress, to our legislatures and other organizations, in a systematic way

with the prestige of the American Medical Association and State Association, and results will follow. I would urge that the American Medical Association come closer to us and among us, that a representative from that organization visit regularly in our states meeting with our representatives, on pre-arranged schedules with pre-arranged programs of telling facts to the public, which they are ignorant of, but want to know. I would urge that that great medium, the public press and lay journals, be used by our Mother Organization for conveying to the public, information which will enlighten them on the dangers of the present medical trend, rather than to devote its whole use to advice as to how to prevent measles or whooping cough. I would urge that our National Association proceed in some systematic way to contact regularly, those thousands who are on the outside. For the National Association to leave it to the states and the states to the individual parish and county units, has not gotten us very far. I would urge the National Association to throw her whole influence of prestige into a militant move of education for the public and a drive for a perfected organization.

I have been told by officials high up in Organized Medicine, that in many sections, there was an unfriendly feeling and attitude on the part of some of the component bodies. If this is true, there must be some reason and a little self analysis would be in order. When the Journal of the American Medical Association refuses to publish the opinion of the President of a State Society on a matter pertaining to Organized Medicine, with the curt reply that it contains nothing new, a little more self analysis is in order.

Closer contacts, more sympathetic feeling and co-ordinated action down the line is needed. The time has come when our state organizations must provide for constant activities in a systematic way, operating under full time trained organizers working in turn with representatives of the National Association, with definite aims and purposes. With such concert of action and plans, the whole truth can be told in a convincing way and we will find a sympathetic and responsive public.

The critic again says, "This will cost money." But the doctors of this country are intelligent men and women and will be willing to foot the bill when convinced that a real effort is to be made.

MEDICAL EDUCATION IN MISSISSIPPI.*

JOHN C. CULLEY, M. D.,

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The education of physicians is a subject which has found a prominent place upon the programs of medical meetings during the past twenty years. Before that time the average physician had given little thought to it. He had obtained his own education at the best school available to him, considering his own particular geographical and financial limitations. If he had sons who wished to follow in his footsteps, he assisted them to get their training in much the same way as he had obtained his own. This does not mean that we saw no progress in medical education up to a quarter century ago. Everyone realized that the young doctor should and could have greater advantages than his father and grandfather had been able to enjoy. But the fact that the state of medical education as such affected every man who possessed the degree of Doctor of Medicine—no matter whether it was one year or fifty since he had graduated—did not, until recently, seem to be generally understood.

The reason for this change of view is to be found in the publication, in 1910, of the findings of the investigators for the Carnegie Foundation, headed by Abraham Flexner. Many of the data contained in this report were a distinct surprise to all medical practitioners; many had never

*President's Address, delivered at the Sixty-fifth Annual Session of the Mississippi State Medical Association, Jackson, April 12, 1932.

realized the true character of the institutions from which they had themselves graduated. The report as a whole caused a great upheaval in all our preconceived notions concerning medical education in the United States. The American Medical Association immediately took action to raise the entrance requirements and increase the pre-medical requisites for admission to all the schools of the country, and the Council on Medical Education which was shortly organized, has ever since been busy elevating the standards of training for physicians. Much has been accomplished, but much still remains to be done. It is essential that each state and local association should inform itself concerning the conditions existing in medical education within its own territory, and be ever on the alert to insist upon the attainment of the highest standards set by the Council, as well as to encourage all students of medicine to be satisfied with nothing short of the best.

The most striking—and most deplorable—fact brought out by Flexner was "that the organization of medical education in this country has hitherto been such as not only to commercialize the process of education itself, but also to obscure in the minds of the public any discrimination between the well-trained physician, and the physician who has had no adequate training whatsoever. As a rule, Americans, when they avail themselves of the services of a physician, make only the slightest inquiry as to what his previous training and preparation have been . . . a vast army of men is admitted to the practice of medicine who are untrained in sciences fundamental to the profession and quite without a sufficient experience with disease."[1]

The first medical men to reach the New World after Columbus had shown the way, were inevitably the product of the universities of Europe, and as civilization advanced on this side of the Atlantic, those youths who desired to flourish the staff of Aesculapius were obliged to travel back to those European medical centers in order to get training. As this was a tedious and highly expensive process only a few were able to follow this plan. It was likewise highly selective; none but the most ardent and intelligent could meet the tests. When these men returned to their homes they were usually ready and anxious to communicate to the less fortunate—generally for a good and substantial consideration—what they had seen and learned. As these foreign-trained men were likely to be located in the larger towns, notably Philadelphia, students gathered about them, so as early as 1750 it was possible for those who desired training in such subjects as anatomy or obstetrics, to journey thither to get it. Such students, returning to the frontier towns, took as apprentices likely young fellows who could curry horses as well as make mustard plasters, and be trained to replenish the family wood pile with skill and dispatch, as well as take off an arm or leg. The apprentice system in retrospect seems crude, yet we know that it turned out some very creditable products. Many a man whose name afterward became famous among early American physicians began his education in this way. Some of the best known of these originated in the South. The names of Ephraim MacDowell and Marion Sims come to mind, although Sims should properly be regarded as a product of a later age, when medical schools had been organized in many sections of the Atlantic seaboard. MacDowell, to use the words of Flexner, "left the Kentucky backwoods to spend two years in Edinburg under Bell; and when they were over, returned contentedly to the wilderness, where he originated the operation for ovarian tumor in the course of a surgical practice that carried him back and forth through Kentucky, Ohio and Tennessee." The South has a right to look back with pride upon these pioneer achievements.

Unfortunately, along with the rest of the country, the South abandoned this high standard, as civilization advanced by leaps and bounds, and all conditions of life be-

came easier. The desire of those who have enjoyed superior advantages to teach their less fortunate younger brothers, deserves nothing but praise. Though they often made money at it, the making of money was not their original object. Their lecture courses were designed to supplement the practical work the student had already accomplished as an apprentice to some reputable clinician. Such courses, after being conducted independently often became integral parts of the teaching at some previously existing seat of learning. Such was the origin of Harvard Medical School and that of the present University of Pennsylvania.

But at the beginning of the nineteenth century the apprentice system was outworn and discarded, along with other social customs which had been outgrown by the rapidly expanding nation. To meet the needs of medical education the didactic school now began to appear. Commercialism took the upper hand. Wherever a certain number of practitioners were of like mind and anxious to eke out the none too generous income from regular practice, there a medical school might be set up, no matter whether there was capital enough to provide equipment, nor skilled instructors capable of passing on the torch of learning. The local men constituted the stockholders; the members of the "faculty" usually divided the fees after the very small "overhead" had been deducted. The interest centered upon inducing as many students as possible to enroll, rather than upon turning out the best educated doctors. Thus the whole system of medical education became thoroughly demoralized.

In this debauchery the South suffered more than the North, especially after the war between the States, for then the majority of families from which the medical profession should normally be recruited, were too poor to permit their sons the enjoyment of the advantages offered by large medical centers, such as Philadelphia and Boston. The impoverished States could not afford to support universities which could give facilities for proper medical education, or even to establish secondary schools where the future medical student might get a proper background for his special training. The proprietary medical school took the student without preliminary examination in many instances; never were the requirements equal to those of the old universities. These conditions prevailed throughout the country—they were in no way peculiar to the South—only here there was perhaps a little more excuse for them.

The proprietary medical schools often proved gold mines to those who promoted them; in consequence their numbers increased until the profits began to dwindle. Greater efforts were put forth to induce young men to enroll as students, the result was a steady decline in the character and ability of those taking the course. When Flexner began his survey a vast number of ill-equipped and generally inferior young men were yearly being added to the already over-crowded ranks of American medical practitioners. Almost every student who made the attempt could by some route—straight or devious—arrive at the degree of M. D. If he failed in one school he could get in somewhere else where standards were even lower. A new medical school could graduate a class the first year of its existence by recruiting students from other institutions and such examinations as they gave were sure to be "passed" by all the candidates whose fees were paid in full. A dozen examples of such practices are cited by Flexner, located in all parts of the United States. I will mention but a single example the Mississippi Medical College, which was established at Meridian in 1906 and graduated a class in 1907.

This brings me direct to the subject upon which I am scheduled to speak—medical education in our own state. Flexner said some rather scathing things about the kind of medical education we were providing, but it is only fair to note that he was just as severe upon many other states, and found far more fault with the North than with

the South. Nevertheless, it is what he said about Mississippi that interests us at the present moment. When he visited us in November 1909 he found two medical schools in existence ,these being, so far as I am aware, the only ones Mississippi has ever had within her borders.

The school at Meridian had then been established for three years; its average attendance as 100, 94 per cent of the students being Mississippi boys. The teaching staff consisted of 19 members, 12 of whom were ranked as professors, the others merely as assistants. There was no dispensary, no hospital facilities other than the privilege held by certain of the faculty members at a small hospital more than a mile away, of whose staff they were members. Of the laboratory facilities we learn: "At the date of visit there was no outfit at all. Subsequent reliable report credits the school with a vat containing four cadavers in a room without other contents, a simple outfit for elementary chemistry and twenty brand new microscopes, but no material to use with them."[2]

I have endeavored to obtain other information concerning the Meridian institution. Dr. H. Lowry Rush has answered my inquiry with the date of organization and a partial list of stockholders and students graduated. In addition he says, "The school flourished and had quite a number of students each year. It was able to meet all its obligations and *to graduate some men who have made good in the practice of medicine.*"

I have italicized this last phrase, for it seems to me to be highly significant. As there are undoubtedly some members of this audience who got their education at Meridian; it should be kept in mind while Flexner's strictures are being cited. Indeed, Flexner himself says in speaking of the "vicious system" which permitted the springing up of so many proprietary medical colleges, that "the best products of the system are hard to reconcile with the system itself." The boy bent on becoming a doctor because of a sincere desire to practice the art of healing will get all that can be had from the poorest school, although that is no argument for the countenancing and maintainance of poor schools.

The other medical college visited by Flexner in 1909 is still with us, and is sufficiently well known to all of you to make it unnecessary for me to say much of its history and attainments. This is the Medical Department of the University of Mississippi, which began as a two-year course only; was later extended to a four-year course by carrying on the third and fourth years at Vicksburg; and was later still, returned to the two-year basis, on which it is maintained at the present time. From Doctor James B. Bullitt, now of the University of North Carolina, I have been able to obtain some very interesting details concerning the early days of Mississippi's only medical school.

The idea of establishing a two-year medical course in connection with our University was a current one at the time of the reorganization of the American Medical Association in 1902-3. The reason for this sentiment among medical educators is explained by Dr. Bullitt as follows: "Many of the then existing schools were doing trivial work in the laboratory branches even though they might be doing well in the clinical subjects. It was felt that the 'academic influence' would improve the scientific quality of medical teaching. It was also thought that geographical separation of the first two years from the last two years would be desirable by preventing the distraction of the student's attention from the laboratory by the clinic . . . Most of the laboratories thirty years ago were conducted by clinicians to whom the laboratory was a mere side issue. It was desired to have whole-time teachers in these branches. A college which could not develop a complete medical school might well conduct the laboratory subjects with whole-time teachers and feed well-trained students into the third-year classes of schools

that had good clinical facilities, but lacked laboratory teachers of good quality."

I am pleased to call your attention to the fact that our orator for the occasion is the one who is responsible for the organization of the University of Mississippi Medical School. He came to Mississippi as Professor of Biology and Physiology, but soon expressed an interest in organizing a Department of Medicine. He was the first Dean and served in that capacity until he left the state in 1924 to assume the position of Dean of the Vanderbilt University Medical School. Not only was he Dean of our Medical School, but he also served as executive officer of the Mississippi State Board of Health from June, 1910, until his departure from our state. During his whole term of office as dean, the standing of the Medical School in the National Associations was unquestioned. It can truthfully be said that the name of Dr. W. S. Leathers is synonymous with Medical Education in Mississippi.

But what I have said of him is in no manner a reflection on those who succeeded him to the deanship. Dr. J. O. Crider served the Department not only as Dean, but as Professor of Physiology. He was most thorough and especially was he to be commended for the efficient, systematic and painstaking manner in which he evaluated the credits and reported the records of the students to the accrediting bodies. He was, it is true, a hard taskmaster, but it could be well said that the student who passed Dr. Crider's work need have no fear as to his future work in other schools. His work as dean brought forth most favorable comment from the various schools throughout the country.

Last, but by no means least, I wish to mention the present dean, whose occupancy of the office was not of his own choosing. In fact, he took it against his will, but greatly to his credit let it be understood that no one could have put his shoulder more closely to the wheel or worked harder against apparently unsurmountable difficulties.

It is not my purpose to re-open what I choose to call a closed chapter in the history of the medical school. All of you know full well the details of the recent upheaval, but as this is the first attempt to record the history of medical education in our state I think it my duty to bring out some of the salient points relative to the "shake up" and its relation to the Department of Medicine. On a certain morning in July, 1930, the whole country, and Mississippians in particular, read the astounding news that several members of the faculty of the University of Mississippi and other state schools had been dismissed.

As a result of this wholesale dismissal the medical school found itself minus the heads of three departments; those who were dismissed by the Board being Dr. J. O. Crider, who was dean and also Professor of Physiology, and Dr. P. W. Rowland, an ex-president of this Society and the only member of the faculty connected with the school since its foundation. Dr. E. S. Sanderson, who was the head of the Department of Pathology and Bacteriology had resigned previous to the "shake up" and negotiations were being made with someone else to take his place.

With the loss of the above-mentioned men, the medical school faculty was composed of the following: Drs. P. L. Mull, J. B. Looper, G. H. Woolett, B. S. Guyton and A. H. Little; the last two being associate professors. There were also several student assistants.

This newspaper announcement together with a telephone message from Jackson to Dr. Alfred Hume, then chancellor, was the only notification that the professors had of their dismissal; nor was any reason ever given for this action.

The immediate action of the various accrediting bodies is now history. The Council on Medical Education and Hospitals wrote the following letter to the Governor of the State, and so far as I can ascertain no reply to this communication was ever received:

July 10, 1930.

His Excellency Theodore G. Bilbo,
Governor of Mississippi,
Jackson, Mississippi.

Dear Sir:

From news clippings and from other authentic reports we have obtained rather distressing news in regard to the University of Mississippi and more particularly in regard to its school of medicine. Of the ten medical schools which are providing for the first two years, or freshman and sophomore years, of the medical course, heretofore, the University of Miss. School of Medicine has been among the leaders from the standpoint of the scholarship of their medical students. For this reason the school has always ranked among the Class A institutions.

For these reasons we are naturally distressed that anything might happen which would prevent a continuation of the high rating which that medical school has heretofore held. We are very much in hopes, therefore, that the matter has not gone so far but that it can be rescinded whereby this high rating can be maintained.

If the changes which are reported have gone so far that they cannot be repaired, of course, the American Medical Association will have no other alternative than to remove the institution from our approved list.

I shall await with interest such information as you can give us showing what has been or will be done in the matter.

Yours very truly,
COUNCIL ON MEDICAL EDUCATION
AND HOSPITALS.

The result of this letter was the reinstatement of Drs. Crider and Rowland. Then it was that Dr. Crider resigned to accept the position of assistant dean at Jefferson Medical College in Philadelphia. So you can imagine how anyone would feel about assuming the duties of dean of a medical school which had lost several of its faculty members who were heads of departments, and the pleasing fact that the removal from the approved list of American Medical Colleges would take place unless certain requirements were met. In the face of such a situation, Dr. Mull consented to accept the deanship and proceeded to reorganize his faculty. And may I here speak a word of praise for our sister institution, the University of Tennessee Medical School, who through its dean, Dr. Hyman, assisted us by supplying a man from its faculty to teach physiology. This fact together with the endorsement and assurance of support from the Mississippi State Medical Association prevented our being dropped from the accredited list of American Medical Colleges and placed the school on probation until the University as a whole could regain her standing in the Southern Association and the people of the state removed all possibility of any further interference from political domination.

After the re-organization and re-instatement of those suspended, we find the faculty composed of the following: Drs. P. L. Mull, dean; P. W. Rowland, G. H. Woolett, J. B. Looper, H. G. Gondolf, C. E. Ward, B. S. Guyton, A. H. Little, Henry Alloway, special student assistant, and Frank A. Wood, full-time student assistant.

Prior to this, very little interest had ever been manifest, either by the medical profession or the laity, in the medical school. Dr. Mull realized that he occupied the position of one who must sell to the profession and the laity of our state something that they already owned but did not appreciate. How well he has done this is evidenced by the whole-hearted support which he has received from all parts of the state and the implicit faith of the students, who, through it all have done excellent work and have done their part in upholding the past traditions of the medical school. They know that they can depend on Dr. Mull to protect their interests. His heart and soul are in our medical school. I count it a privilege to have been associated with him in his labors and I commend him to you as one worthy of your admiration and support.

In accordance with the suggestion of Dr. Leathers, Chancellor Fulton decided to begin a two-year medical school at the University of Mississippi. But when it was opened in September 1903, there was no building in which to house it. On the top floor of the newly erected north wing of the Lyceum Building two moderate-sized rooms and one very small office room were dedicated to the cult of Aesculapius. Into this limited space were crowded the departments of histology and physiology, pathology and

bacteriology. Equipment was very scanty. One sink and about a half dozen gas jets and a few tables constituted the fixed equipment. There was one small incubator, one microtome, a modest amount of glassware and just enough microscopes to meet the needs of the original class of students, a very small number. Dr. Bullitt himself taught first anatomy and pathology, later pathology and bacteriology, and still later, anatomy alone. His account of these early struggles makes amusing reading now, but it was no laughing matter in the early days. "If I remember correctly," he adds, "after the purchase of the necessary microscopes, there was less than $500 left for equipment and supplies in these laboratories during that first year. There was no library except such as the teaching staff furnished."

Their greatest problem was the dissecting hall. No one on the campus wanted it anywhere near, and there was no building available for it anyway. A small frame shack consisting of an office ten feet square and a dissecting room about 10 by 15 feet, was erected in the woods back of the old dormitory, north of the Lyceum Building. The present Education Building occupies the site of this old dormitory, in one end of which the University Librarian then occupied quarters. Shortly after the dissection hall was erected she went to the chancellor complaining of the terrible stench coming from that department of the medical school, and her objections were strongly supported by other members of the faculty who alleged that life in that part of the campus had become almost unbearable. The dissecting hall simply *must* be removed far enough to prevent their being aware of the smell of the decomposing bodies.

So disturbed were these protestants that they were only partially pacified upon being informed that *the offensive building was still absolutely bare and empty* because the appropriation for the Medical School had not sufficed to enable them to procure any bodies for dissection! At that time there was no anatomical law in Mississippi, so dissecting material could not be legally obtained. Dr. Bullitt remarks that the faculty was unwilling to resort to the ancient methods of grave robbing which many schools had employed a generation earlier. This reminds me that an article which appeared recently in The Atlantic Monthly, written by no other than Abraham Flexner himself, which vividly describes how more than once, in his youth, he had taken part in these grave-robbing forays.

The teachers thus found themselves in a terrible quandry, for Dr. Bullitt had accepted the chair of anatomy upon being informed by Chancellor Fulton's legal advisor that bodies could readily be obtained from the state charity hospitals. Not only did this prove to be untrue, but it was found illegal even to purchase them from medical schools in other states. Finally the Memphis Medical College, which had an abundance of dissecting material, offered their unfortunate Mississippi colleagues the courtesy of shipping bodies to them for burial in their state. These were duly buried according to agreement, but only after they had done a valuable service to the State University. Dr. Bullitt remarks that very likely all concerned were liable to prosecution under the law, but their consciences were innocent of any moral wrong. Under this arrangement they secured four bodies the first year. Later the passage of the anatomical law permitted them to supply their needs from the two state hospitals at Vicksburg and Meridian.

For three years the quarters described served while agitation for an appropriation for a medical building was being kept up. The present building was erected in 1906, but even then it was a struggle to secure equipment, for there was no regular budget for the medical school. The University administration, the Board of Trustees and the Legislature were all in favor of this new development within the University, but none of them in any degree appreciated how much money was necessary for the proper conduct of those laboratories. The

funds available were small, but after the first two years of struggle they managed to maintain "at least a respectable equipment." The students worked enthusiastically, their results being shown by the good standing they attained in their third and fourth years at other institutions, as well as in the standing many of them have attained in the profession in subsequent years. A roster of the classes during this formative time shows some who are now leaders of the medical profession in the state, as well as others who occupy positions of prominence in other states.

When Flexner visited the school in 1909 the entrance requirement was a four-year high school course or its equivalent. More than one-half the entering class for that year had had two or more years of college work. The total attendance was given as 39. From a bulletin issued in 1925 by Dr. J. O. Crider, who was then dean, I learn that up to that year 309 men had completed the two-year course, of whom 172 had academic degrees. Since it was founded this school has maintained a uniformly high standard of medical education, and the training received by the students is recognized by the best medical schools in the United States, which receive its graduates into their third and fourth year courses without examination. It is rated A-Grade according to the classification of the American Medical Association's Committee on Medical Education. The excellent work it has been doing and is still accomplishing is attested by the records made by its students in the colleges in which they have completed the medical course, their uniform success before state examining or licensing boards and their enviable reputation as practitioners of medicine.

The changes which have taken place since Flexner wrote have not been many, but they have all been milestones on the road of steady progress. As the American Medical Association has continued to raise the standards, Mississippi has struggled to meet them, and the fact that she did not collapse and pass out of existence, as the school at Meridian did, is one of the best proofs of her intrinsic strength and true value. The physical properties of the school have been augmented and the teaching staff enlarged. A $200,000 hospital has recently been built on the University campus which will give sufficient facilities for the teaching of physical diagnosis to second-year medical students, and will add to the clinical facilities heretofore so largely lacking.

I have been moved to dwell especially upon the wisdom of continuing this medical school upon the basis on which it now stands, neither trying to convert it to a complete four-year course, nor to set up an opposition four-year school independent of the University, as has been agitated in some quarters, because there seems to be a prevalent impression to the effect that it is of the utmost importance to educate Mississippi physicians in Mississippi. While there are undoubtedly some arguments in favor of making medical education a "home industry," I do not feel they are sufficiently weighty to overbalance those upon the opposite side. To quote once more Flexner's report, "The state (Mississippi) is indeed not favorably situated for the entire training of its own doctors. The state university, the only institution to which the task could fall, is unfortunately located . . . The first half of the school"—the last half was then being given at Vicksburg—"at Oxford, though distinctly creditable, is far from satisfying its faculty. It is a question whether the University would not do more wisely to concentrate its outlay on the Oxford branch. Up to this time the medical profession of Mississippi has been educated mainly in the proprietary schools of the Southern states. It would be fortunate indeed if henceforth its members should get at least their first two years at Oxford. To make itself the main factor in the education of the physicians of the state, the University should keep its entrance requirements in touch with the secondary school system. Its present and prospective facilities do not really warrant a higher require-

ment. Besides it can perform a more useful service by training a relatively large body of students at the high school level than by training a few at a higher standard . . . where a high school standard, or even less, is enforced, well chosen teachers, well equipped and liberally sustained laboratories, are capable of producing a very useful type of physician. The present duty of the Southern state universities is not to press prematurely to a standard that either cannot be enforced, or that, if enforced, will relegate the main army of students to medical schools without either facilities or ideals, but to endeavor to get hold of a sufficient body of students to meet the demand on an enforced basis, or improve their facilities so that this number can be well trained, and to urge the legislature to make their standard the practice standard of their respective states."

Though enough time has elapsed since this report was made to permit the sons of the men who were students at Mississippi then, to be coming up for *their* medical training at the present time, its recommendations are still sound. By concentration on this two-year course, we have, as I have just shown, been able to carry on an educational institution which, insofar as it goes, would be a credit to any state in the Union. Mississippi will never be financially able to support a four-year school which can compete with Vanderbilt, Tennessee, Tulane, Louisiana or Emory. It would require an endowment of at least ten million dollars even to start a new school, and I am certain that the state can never hope to raise such an amount for medical education alone. But the state's very poverty is favorable to the maintainance and continuance of the two-year course. As Dr. Bullitt has shown us, it is not necessary for the first two years to be so closely allied with the last two years, and in a small town, the two-year course can be carried on upon exactly as high a plane as would the four-year course be in a larger center of population. Most of the work is theoretical, or carried out in the laboratory, so it can be conducted in connection with any well-organized university. The fact that it is a state institution and that living conditions are very inexpensive in Oxford, makes it possible for Mississippi boys to take their first two years in medicine at much less cost than they would have elsewhere. The students who prove worthy, by survival of the fittest, are prepared to go outside the state to finish their medical training, either at some of the excellent schools close at hand, such as Tulane, Vanderbilt, Tennessee or Emory, or, if they can command the time and money, to some of the other medical centers of the country, all presenting clinical and hospital facilities which their home state may never be able to provide for them.

I have recently made a complete survey of the students who have attended the University of Mississippi Medical School, which may be summarized as follows:

Total number of graduates from 1905 to 1929, four hundred and twenty-nine. Under the present requirements the degree of Bachelor of Science is conferred upon those who have completed the two years of prescribed college work and the regular course in medicine, and in addition, have done no less than thirty-two semester hours in the University's College of Liberal Arts. Of the 429 who fulfilled this requirement, 411 went on to complete their medical work and obtain the M. D. degree. It is interesting to note the different states to which these men went to finish their studies: Louisiana, 155; Tennessee, 61; Pennsylvania, 54; Virginia, 44; Illinois, 36; Kentucky, 16; Missouri, 12; Georgia, 10; New York, 11; Maryland, Arkansas and Mississippi, 2 each; and Colorado, Massachusetts, Michigan, Oklahoma and Oregon, 1 each.

Of this number of graduate physicians, 136 are now practicing in the State of Mississippi. The fact of our state's being so largely rural in its population distribution probably prevents more of our boys from settling down to practice at home. The total cost of a medical education is so high, and the remuneration from country prac-

tice so meagre, that there is little inducement for a really able man to settle in the rural districts. In order to make a living and to offer his family any of the advantages to which his social and intellectual position rightly entitle them, he is almost forced to hang out his shingle in a town of some size, so he will not be obliged to depend altogether on a country practice. Since the general use of automobiles this has become far easier than it was even a single generation ago, and in a state so located as is Mississippi, where winter storms and heavy snow need not be reckoned with, there is no need for even the remotest country dweller to go without doctors' aid, if it be urgently demanded.

This calls to my mind a recent report of a sub-committee of the Senate Committee on Universities and Colleges. This committee, headed by a man who was at one time the head of one of our state institutions of learning, recommended that the School of Medicine be discontinued because of the excessive cost and by figures showed that it cost the state $500.00 for each medical student. He failed to show that two members of the medical faculty also teach in other departments of the university, thus reducing the per capita cost in the medical school. Likewise, he failed to credit each student with $200.00, which sum is paid to the university in tuition and other fees, leaving a net cost to the state of approximately $300.00 per capita per year or $600.00 for the biennium. The total per capita cost for the whole university for the session of 1931-32 was about $400.00.

Commenting on the above report, a certain newspaper editor agreed with the committe that the Medical School should be discontinued and relying on the validity of the report, felt justified in making the assertion that the school was useless. Let us see how useless it is. Our boys could not go to a school in another state for twice the amount they have to pay at our medical school. Our school provides a means for many poor boys to secure a medical education, who otherwise would be unable to complete a full four years course at other schools. Does the state lose or gain? Granting that the 429 students enrolled during the life of the institution cost the state $500.00 per capita, this will amount to $418,500.00 for the two years course.

I have shown that of this number 136 are now practicing in the state. It will readily be agreed that these men are earning $3000.00 per year. It will also be granted that if this is all they do earn, every cent of it will be spent in the state. Then in only one year they will have spent in the state $408,000.00 and in a two-year period $816,000.00. I leave it to you to be the judge of its uselessness.

In the same report we find this last paragraph which I quote: "There is a growing dearth of general practitioners in the rural districts, which we are trying the alleviate by state hospitals and charity wards. We are finding such alleviation too costly. It would be a great piece of work if our Board of Health and the medical profession of the state would evolve a plan by which general practitioners could be equipped to treat in our rural districts the usual diseases without having to take the many years of expensive training now required to make specialists by standard medical institutions."

Here is a committee trying to standardize our educational institutions and endeavoring to restore our colleges to their previous place in the accrediting associations and in the same report asking the medical profession to turn out physicians who will admittedly be below the standard set by the medical profession itself.

Is not the sick child or mother or father of the family in the rural districts just as dear to their loved ones as to the rich man or the man of moderate means in the city? Does it not require just as much skill to treat diseases in the rural sections as in the city?

To quote again from the recommendations: "In recommending the discontinuance of the Medical Department of the University, we do so with the deepest regret. However, should this department be con-

tinued, it should be standardized, and in our present financial condition we cannot meet the expenditures required by the standardizing agency."

The requirements spoken of are merely recommendations made by Dr. Rygh to the Council on Medical Education and Hospitals. So far as I can determine no effort was made by the committee to consult the accrediting board, seeking a modification of their demands.

What I have said is not intended as a criticism nor an indictment of the committee. I feel, however, that they would have shown greater interest in Medical education had they made a closer and more thorough investigation before recommending the discontinuance of the school. We have by no means lost our medical school and you as citizens of Mississippi can do a great deal toward the continuance of this much needed department at the State University.

My subject is such a broad one that it has been quite impossible for me to do more than sketch in lightly some of the chief factors surrounding Mississippi's problem in educating her boys who wish to become doctors. I have attempted to show that the two-year course now in operation in our state university offers the best and cheapest means by which a native son of our state may attain the degree of Doctor of Medicine by finishing his studies somewhere outside its borders. This plan has now been in operation for almost a quarter-century, so it can by no stretch of imagination be any longer regarded as an experiment. If anyone doubts that this system can turn out good doctors, let him glance at the records of the men here in this room. "By their fruits ye shall know them."

Likewise, I have tried to demonstrate the inadvisability of trying either to convert our present school into a full-time one, or to start a new school somewhere else. There are still far too many second rate medical schools struggling along on insufficient funds and inadequate equipment. Mississippi is fortunate that at present there are none such left within her borders, and it is to be hoped that we will not be persuaded to undertake the folly of establishing any within the state. We do not need a greater number of doctors here; there are already 1,567 physicians for our 2,000,984 of population according to the American Medical Association Medical Directory for 1931, that is, one for every 1276 people. But we DO need men to replace those whom we lose by death or migration. If we can give those boys a solid foundation in the two years at Oxford and then send them to some of the excellent schools in the neighboring states to complete their course, we will be providing far better medical education, and giving the people of the state better medical attention without increasing their taxes. We will also be upholding the standards of medical education, not alone for ourselves but for all the people of the United States, to whose interest it is—although they themselves are seldom aware of it—that only the best instruction should be considered good enough for those to whose skill and knowledge the lives of all our people must be entrusted.

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LOOKING INTO THE FUTURE.*

ALTON OCHSNER, M. D.,†

NEW ORLEANS.

The completion of the medical school training with the award of the degree of doctor of medicine represents a memorable period in a young physician's life, largely because it attests certain definite accomplishments. Graduation from medical school, however, momentous as it is, should cause practically no change in the individual as regards his attitude toward his chosen life's work. Commencement

*Ivy Day Address, June 8, 1931.

†From the Department of Surgery, Tulane University School of Medicine, New Orleans.

signifies the beginning of one's career, and this is especially true in medicine in which continuous study is imperative. All too frequently there are some among the graduates who believe that once they have become licensed physicians that their obligations as regards training are nullified. Medical graduates today are and necessarily have to be well-grounded in the fundamental principles of the science of medicine. It is not the desire nor the purpose of recognized medical schools to develop special practitioners, because such is impossible in the time allotted to the undergraduate study of medicine. It is the function, however, of these institutions (1) to train their students in the fundamentals of medicine, the prevention and diagnosis of disease, and the treatment of the commoner conditions to which the human race is subject; (2) to teach their students how to continue to obtain knowledge, since medicine is far from static, but is progressive; and (3) to instill in them the desire to do their best possible work.

You, as the graduates of Tulane University, have passed through the first period of your training and have successfully cleared the first group of hurdles. You have worked hard and have been trained according to the first requisites outlined above, and also, I hope, according to the second and third requisites as well. It is well to realize, however, that your knowledge of medicine is meager, that only the first lap of your journey has been completed, and that continued study is necessary in order that you may be able to serve your patients in the proper way. The future of a young physician just graduated from medical school is a bright one. It is important, however, for him to realize that he has certain obligations which he must meet. These obligations are: (1) to his patients; (2) to the community; (3) to his colleagues; and (4) to his alma mater. The obligations which a physician has to his patients are great indeed and never is it possible to expend too much effort in discharging these duties. When consulted by a patient, careful and thorough history taking and examination are of primary and utmost importance, because only in this way can true data be obtained. Then a careful analysis of all the data which are at hand must be made in order to evaluate the various symptoms and signs in order to weigh the evidence in favor of or against various morbid processes. Only in this usually prolonged and tedious way will one be able to arrive at a correct diagnosis in many cases. It is true that frequently an individual may make a spectacular showing by suggesting a diagnosis without going through the process mentioned above; however, that same individual will make many mistakes and certainly many more mistakes than he would, had his examination and analysis been thoroughly executed. Thorough and exact methods only should be used, because medicine at its best is an inexact science, and it behooves us as physicians to make it as exact as possible. Laboratory examinations should be used as an aid in diagnosis. However, one should be extremely careful not to rely upon the "laboratory" alone to make the diagnosis, because in the majority of instances if there is a discrepancy between the clinical and laboratory findings, one should depend upon the clinical findings.

The physician owes it to his patients to be progressive, to keep abreast of the times, and to keep informed of medical progress. Unless this is done, his obligations to his patients are certainly not met. Imagine the fallacy of attempting to practice medicine successfully today if one were not familiar with the liver feeding in pernicious anemia or the use of insulin in diabetes. Equally as great advances will be made in the next ten years, and he who does not progress with the times will soon become "obsolete." Progression may be accomplished in a number of ways. A valuable way is for the physician to familiarize himself with the medical writings and to keep

abreast of the times by subscribing to and diligently reading good current medical journals. Even now, I am sure, you all realize that, in order to evaluate that which is written, it is important to develop an analytical mind, as a great deal is published which is of little significance. However, such rarely finds its way into the better medical journals.

Keeping in touch with medical progress is also accomplished by visiting educational centers and clinics, where not only may one become familiar with the methods employed in these centers, but also will be stimulated to do better work. Such pilgrimages should be made frequently, preferably at least once a year and certainly with intervals of not more than two years. In those instances where one is unable to leave his practice as often as this, it is desirable and imperative that postgraduate courses in recognized educational institutions be taken every three or four years, at which time the newer advances in the science of medicine can be presented to the physician in a systematic and complete manner.

As in any business, the physician should from time to time, preferably yearly, take an inventory in order to determine his results. No successful business man would consider running his business without taking an inventory from time to time, because only in this way can he determine what has been accomplished. From such an analysis of one's results is it not only possible for the physician to determine whether his therapy has been successful or not, but also the results will be of aid to his fellow practitioners, especially when compared with their own. Such an inventory is possible only when the final outcome of the case is known, which can be determined by means of a careful "follow-up." Altogether too frequently a physician is content with knowing the immediate results in a particular case, whereas the final end result is the one in which he should be interested. To the modern physician subsequent morbidity should be as important as is immediate mortality.

The obligations which a physician owes his community are varied. As individuals trained in the healing art, it behooves us to practice preventive medicine not only individually, but also collectively in order that disease may be prevented as well as controlled. The early isolation of and the immediate reporting of communicable diseases to the health department should be conscientiously and rigidly adhered to. Occasionally a patient will attempt to prevail upon the physician not to report a communicable disease, because of the fear of quarantine. In granting such a request the physician not only violates the law, but also subjects the community to the dangers of the spread of disease. The physician should take an active part in the educational program of the community, especially as regards education of the public along health lines. This can be accomplished through the medium of the schools and other institutions, but should also be done through organized medicine and in a thoroughly planned and systematic manner. The assumption by the medical profession that their only duty is to cure disease once it has become established is entirely wrong and obsolete. This is indeed a day of preventive medicine, and it is necessary for the physician to do his individual part in perfecting it.

The obligations which a physician owes his fellow practitioners and colleagues are definite. In this day of specialization the need for cooperation between physicians is especially important. The subject of medicine has become so broad in its scope that it has become necessary that a certain number of physicians train themselves in one particular field of medicine. As necessary and important as these specialists are, it should be realized that they have distinct disadvantages in that by virtue of the fact that all their time and energy have been expended in perfecting themselves along one particular line their vision as regards

medicine as a whole has become more or less warped. Never will they be able to take the place of the family physician and general practitioner. The need of close cooperation between the family physician and the consulting specialist cannot be overemphasized, because only in this way can the maximum benefit be obtained by the patient. One is obligated to be ethical toward his colleagues, and in medicine probably more than in any other profession is the golden rule applicable. One should abstain especially from destructive criticism of fellow physicians, because such is not only harmful to the individual, but also is detrimental to the medical profession as a whole. Occasionally such criticism may seem just. However, unless one has all the information at hand, it is impossible to criticise fairly because of the question of judgment, which is so important in the practice of medicine. One should always stand in readiness to give aid to a colleague; and should never hesitate to ask for consultation, because not only are two heads better than one, but also often the responsibility to the patient is too great for one individual to shoulder.

The physician also should endeavor to do constructive work in some way. This may vary from extensive research performed in the educational institutions to the analysis of one's own results obtained in his private practice. Both are equally valuable. Obviously the results obtained in a small community following a careful analysis of a group of well studied cases is of more value to a physician working under similar circumstances than are the results obtained in a large educational center. It is by this careful analysis of results and the free interchange of thought that medicine can continue to progress.

Last, but not least, I wish to discuss the obligations which the physician or any other student owes his alma mater. The strength of an educational institution depends upon the loyalty of its alumni. It should be remembered that graduates of a class A medical school, even though they have expended large sums of money in obtaining their medical education, have contributed only a small part of the sum which is necessary to provide them with that education. Medical education is the most expensive type of education, from the university standpoint, that can be obtained. There is, however, a much deeper feeling which a graduates has for his alma mater than one merely of gratitude and that is a feeling of loyalty and cherished memories, which binds him to his institution of learning. Your alma mater is, and always will be, interested in you. Make your subsequent accomplishments and progress a source of pride to her.

PLANNING THE PLASTIC OPERATION OF THE FACE.*

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The current conception of plastic surgery, no doubt gathered from newspaper accounts, is that of an unbeauteous, graceless or even repellant countenance by some miraculous transformation bursting forth with all the grace and splendor of Helen of Troy and the enchantment of Aphrodite. Ridiculous though this impression be, it is fostered by self-styled cosmetic surgeons, paraffin injectors and the like. So-called cosmetic surgery is mentioned here only for the purpose of condemnation. Reference is made here to that type of surgery only that is directed to correct or alleviate deformity or disfigurement of the face in an effort to restore the individual to a normal and happy existence.

Given a case with a facial deformity, the first and foremost factor to be considered by the surgeon is the amenability of that case to operative treatment. For

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Fig. 1a: Model of sebaceous cyst of lobe of ear before operation.

the sake of the patient and the reputation of the surgeon all doubtful cases should be refused. The planning of the procedure must be done with meticulous care. Although there are certain well-established principles of plastic surgery that must serve as the basis of treatment, each case must be carefully planned as a distinct entity.

Several days are often required for the planning of an operative procedure on the face, and since it is impractical to keep the patient before the surgeon, plaster masks may be prepared and serve as a most accurate replica. The outline of incisions may be most satisfactorily mapped on the model which serves as a guide during the operation after the incision has been made and the landmarks distorted. For the information of the patient the model serves

Fig. 1b: Same as Fig 1a after operation.

better than the photograph to demonstrate the comparison between the original defect and the result of the reconstruction.

PREPARATION OF THE MODEL.

The patient is placed upon the table in the dorsal position. The face is thinly coated with vaseline and the eyebrows thoroughly greased. Small pieces of wet tissue paper are placed over the palpebral apertures and rubber tubes put into the nostrils for breathing. Solvite paste is prepared very thinly and first poured into the depression of the face. After that, the

Fig. 2a: Old fracture of skull with extensive depression in frontal bone and loss of entire supro-orbital ridge. Result of kick by horse fifteen years previously.

paste, all air bubbles being carefully removed, is poured over the face in a thin sheet and allowed to set. This requires but a few minutes and causes surprisingly little discomfort to the patient. This impression is removed from the face, the rubber tubes being carried with the solvite. This impression is then filled with thin plaster of paris paste, again being very careful to remove all air bubbles. When the plaster has set up the two sections are separated by immersion in boiling water. The solvite softens and crumbles away, leaving the plaster model of the face.

Plaster models of the ear can be made with more facility than those of the face,

Fig. 2b: Same as Fig. 2a three months after cranioplasty.

Fig. 2c: Plaster model of face showing defect in forehead.

the difference being here that the impression is made in two halves, a posterior portion of the solvite material being placed back of the ear molded snugly up to fit in with its contour and smoothed off around the outer edge of the auricle. This outer edge is coated with a separating fluid called separatine. Then the anterior portion of the impression is poured on and the impression of the ear is taken in a bi-valve fashion, there being anterior and posterior sections. It is removed from the ear by separating the two halves. These two sections are filled with plaster of paris cream and squeezed together. After the plaster

Fig. 2d: Metal patterns filling defect on plaster model.

has set it is placed in water and boiled, the ear model being freed by boiling the solvite impression away.

The first model (Fig. 1a) illustrates a sebaceous cyst which had involved the whole lobe of the ear, before operation. The second model (Fig. 1st) shows the ear after the cyst had been removed and healing complete.

The model here (Fig. 2c) is that of a face before operation showing an osseous defect of the forehead. This was the result

of the kick of a horse received fifteen years previously. There is an old fracture of the skull with an extensive depression of the frontal bone and loss of the entire supra-orbital ridge. The operation was planned on this model.

The defect was built up with warmed dental wax until the contour of the right side of the forehead was exactly the same as that of the left side. When this wax had hardened it was incised with a knife and

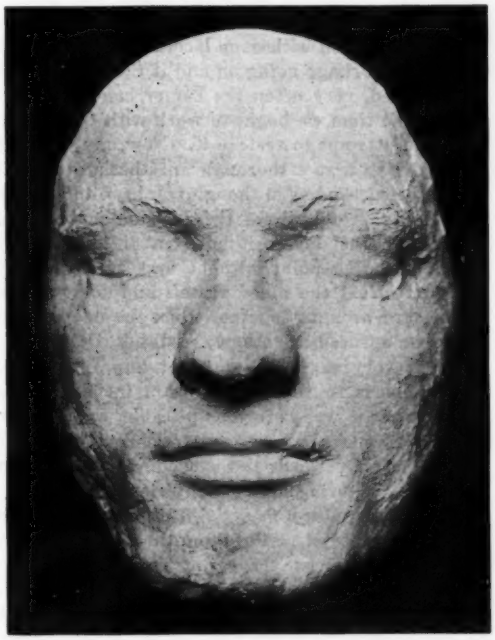

Fig. 2e: Plaster model showing result 2 years after operation.

removed in pieces the width of these metal strips you see here (Fig. 2d). These metal strips were made by investing the wax in dental investment compound, casting it in aluminum in the same manner used by dentists in making gold inlays. These metal strips were sterilized and used during the operation as models by which we cut our cartilage grafts. These grafts, when they were properly shaped, were ready to be fitted into the defect.

This model (Fig. 2e) shows the face two years after operation.

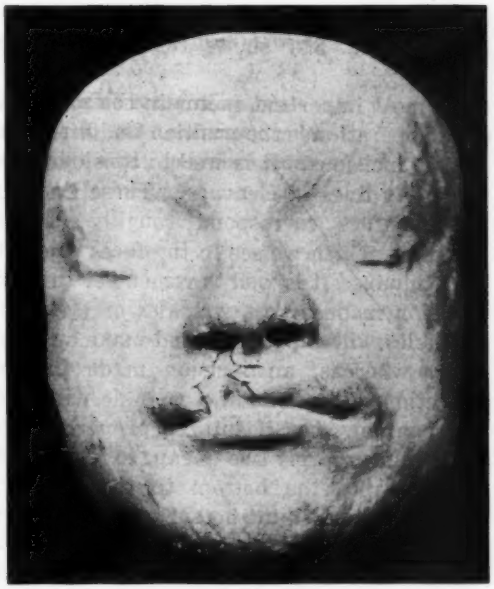

Fig. 3a: Plaster model of uni-lateral hare-lip. The incision has been outlined on the model.

The next mask shows a harelip before operation. You can see the outline of our incisions planned on the model before operation (Fig. 3a). After the lip had been cut during the operative procedure and the landmarks distorted, the model was

Fig. 3b: Same as Fig. 3a four months after cheiloplasty.

used as a guide in our reconstruction. The model (Fig. 3b) shows result after four months.

A most important factor in the planning of an operation is the position and direction of the incisions. It is well to consider here Langer's lines of cleavage. These lines of of the face correspond roughly to the wrinkles which we see in the faces of older individuals. It is well to remember that an incision made across wrinkles or potential wrinkles will gap widely and make an ugly scar, whereas, an incision made in the direction of the axis of a wrinkle will give us a narrow scar if sutured properly. By suturing properly we mean to close the wound from the bottom to the surface. Most scars fall into the surgeons hands to be removed as a result of improper handling at the time of the accident. When a wound is deeper than the skin itself and the superficial fascia is cut, unless the fascia is sutured at the time the skin is sutured the scar will widen and become most unsightly.

Another important consideration is the suture material. The skin of the face should never be sutured with catgut. After catgut has set a while in the skin, it is acted upon by tissue juices and swells causing a large scar at the point where the suture passed through. After the catgut has been in place for a while it stretches and allows the wound to gap.

If the wound caused by an accidental laceration is jagged or there is possibility of infection, the wound should be thoroughly cleansed and a debridement done. We should aim always at primary union with perfect approximation of skin edges. In the face there is usually very little tension on the suture line, especially so if the incision is in the direction of the cleaverage line. Very small bites should be taken with the needle and the sutures should be placed close enough together to give the best possible approximation of the skin edges.

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DISCUSSION.

Dr. C. A. Sheely (Gulfport): I have been practicing, as every surgeon has, plastic surgery since the advent of the automobile. We are all familiar with the irergular, often deep scars and lacerations of the face brought to us in the automobile accident cases. They come to the hospital; no patient wants a scar, and the problem immediately presents itself, the restoration of the perfect contour of the face with as little scar formation as possible and this pleases the patient very much if we can do it. These cases come often with deep lacerations, often with active hemorrhage going on and if the hemorrhage has stopped, very often the hemorrhage re-occurs just at the time we begin to work with the laceration and attempt to restore it. Now, my plan has been always first a thorough anesthesia, and that has to be secured even though you have to enlarge the incision, and where the incision is down to the deep vessel layers it is often difficult to get to the bleeding point without first enlarging the incision. Next the blood vessels and surrounding tissues are brought together, then the deeper vessels are sutured together. I think Dr. Rush's paper is very explicit along that line. Then the next point is to restore that skin incision to as nearly what it was before as possible, and I know of no procedure where equal approximation of the cut edges rewards the surgeon so much as in the proper suturing of these injuries.

As to the suture material I thoroughly agree with Dr. Rush, but at the same time I feel almost sure that so far we have not yet had a suture material which exactly meets all the conditions. The first point of all, the suture material should be non-porous, and the next point, I believe we get better approximation if it is slightly elastic. The next point is that you let your work stand for itself without interference for as long a time as you possibly can, and then another thing, a very important thing, you should not allow your suture material to stay in these incisions a great length of time, four days as a rule, on account of the very vascular condition of the circulation of the face, the wound is healed and the sutures can be removed without scar tissue.

Dr. W. H. Frizell (Brookhaven): I want to ask the essayist a question. He spoke of the nature of the sutures but he did not mention the method of applying them, whether intradermal or cross section. Please answer that.

Dr. Leslie V. Rush (closing): So far as the closure of the incision is concerned, we have sev-

eral choices. I think that if an intradermal suture is to be used the best type is that of Dr. H. Lyons Hunt. It is a combination of the intracutaneous and the over and over continuous suture. There is a tendency on the part of the intradermal suture to slip and this over and over combination (indicating on black board) prevents the suture from slipping. A suture that is introduced intradermally, regardless of what material you use, causes a slight absorption of the tissue peripheral to it and we usually get a slight depression of our scar. The closure we like best is a running suture of 00 catgut in the subcutaneous fascia with very small interrupted horse hair suture in the skin itself.

THE TECHNIC AND INDICATIONS FOR SPINAL ANESTHESIA.*

J. GOULD GARDNER, M. D.

COLUMBIA, MISS.

Since the time of Hippocrates down through the ages the art of medicine and surgery, gradually loosened from the bonds of superstition and witchcraft, has become the greatest science and the greatest blessing to mankind.

Noteworthy, and in gratitude and honor to our predecessors, was the advent of anesthesia, a godsend to the surgical patient. Time and progress marched hand in hand, just as transportation has changed from the one-horse shay to the automobile and aeroplane so have the anesthetics improved and changed. Today spinal anesthesia has a very definite place in surgery and should replace inhalation anesthesia in many operations below the diaphragm.

TECHNIC.

The technic of spinal anesthesia today is not perfect but by careful study, careful records, proper care to detail and research, the technic will improve in usefulness and safety.

The first prerequisite for spinal anesthesia is that the anesthetist be able to interpret the unusual happenings during an operation. This necessitates an understanding of the physiological background. It is a sad indictment but true, that a great number of surgeons pay so little attention to the qualifications of the anesthetic or the best suited to the patient.

Our technic is as follows: Before the patient receives any medication the blood pressure is carefully taken and recorded on the anesthetic chart along with the pulse rate and respiration. The patient receives fluids freely up to the time of operation excepting gastric and high intestinal operations. One and one-half hours before operation the patient is given a capsule of one and one-half grains sodium ethyl-1-methyl-butyl-barbiturate. This is repeated 30 minutes before operation. The dose varies according to the patient. If for any reason vomiting occurs one-eighth to one-fourth grain of morphine is given.

The patient quieted is taken to the operating room, placed on the table on her right side. The back is prepared with a 4 per cent mercurochrome-acetone-alcohol mixture. With the equipment ready for performing the lumbar puncture, the patient's knees are flexed upon the abdomen, the head bent forward, so that the chin rests on the chest, the back bowed out. The shoulders and hips should be in the same plane.

The position of the patient during spinal puncture is a matter for each anesthetist to decide. Our preference is with the patient lying prone, as indicated above. There are many patients operated upon with spinal anesthesia who are physically unable to sit up, others may be frightened, shocked or faint. Surely they are more comfortable and safer in the horizontal position than they are sitting humped over on the edge of the table. If the surgeon cannot do a correct spinal puncture with his patient lying correctly, his technic is at fault, not the position of the patient. He needs training—not posture.

Puncture: Locate the interspace desired, then using a 25 gauge needle, two c.c. of one per cent novocaine and three-fourths grain of ephedrine are injected into the skin and the interspinous ligament. Spinal punc-

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ture is made in the center of the wheal raised by the first injection. The puncture should be made at right angle to the long axis of the spine—care should be taken not to deviate to right or left and never attempt a puncture through the laminae. When the puncture is made there is a slight snap, a loss of resistance to pressure, the needle advances easily, the stylet is removed and spinal fluid should flow through the needle. If no fluid appears rotate the needle on its own axis—then if no fluid go a little deeper. If bone is felt it is the body of the vertebra, and you have deviated to one side. Withdraw needle and reinsert at exactly right angle to the spine.

The kind and size of a lumbar puncture needle is important, it should not be larger than a 20 or 22 gauge, made of rustless steel with a point ground off to a taper of 45 degrees. A small needle will not injure the cauda equina, there will be less seepage of spinal fluid through the puncture and less, if any, intradural hemorrhage. There will be no rust left in the puncture track and as these needles are very flexible there is little danger of breakage in the spine—a very embarrassing accident.

We have found that by proceeding through the skin and the interspinous ligament with the tack described by Sise,[1] there is a definite advantage over using the ordinary heavy lumbar puncture needle. The tack makes the opening through the skin and tough interspinous ligament, but is not long enough to pierce the dura, so it is possible to insert a very fine needle and stylet through the lumen of the tack and this penetrates the dura, making a very fine hole which closes spontaneously, if one keeps the bevel pointed toward the ceiling so as merely to split the longitudinal fibers of the dura. This technic will reduce post-operative headaches to a minimum.

The dura penetrated, the stylet is removed and the spinal fluid drops from the needle into the sterile novocaine ampoule previously opened, from two to four c.c. are dripped into the ampoule. The stylet is inserted into the needle very cautiously, just far enough to stop further leakage, the novocaine is dissolved in the spinal fluid in the ampoule by drawing it back and forth two or three times through the syringe all of the fluid is drawn into the syringe, the air expelled, the stylet removed and the syringe carefully locked on the lumbar puncture needle. The solution is then injected at the rate of one c.c. to every two seconds; the rate of the injection and amount determines somewhat the height of the anesthesia desired. If barbotage is used once or twice during a total of four, six, never more than eight c.c. of fluid, the anesthesia will go to the costal margin.

Some workers have advocated large doses of novocaine. Denman regularly uses as high as 300 mgm. We never use over 200 mgm., and for many operations 50 to 100 mgm. is sufficient. For example, in suprapublic cystotomy, in urethrotomy or for a painful cystoscopy 50 to 60 mgm. of novocaine crystals in the third lumbar space give an excellent result. The lower the segmental nerve block, the safer the case should be.

Immediately after the injection is made the patient is turned on his back and put in the Trendelenburg position. Blood pressure readings are taken every three to four minutes for the first half hour, afterwards every five minute. The previous reading made in the patient's room is used as a guide, readings above or below this point are carefully noted.

If there is a drop in the blood pressure of one-third the normal preoperative level we begin immediate treatment. Early treatment of vascular depression is one of the best of prophylactics against further depression and possible collapse. Before a certain point is reached in the progress of the depression, the blood pressure may be easily controlled by means of subcutaneous medication, but after this point is passed, the circulation in the tissues is too slow to

pick up medication readily — the patient therefore is out of control by the simple method, and intravenous medication becomes necessary.

I will add—The point at which treatment should be started varies. In general it should be started earlier in a rapid drop in pressure than with a slow sag. It is important that treatment should not be delayed until the patient is in poor condition, obviously it is essential when spinal anesthesia is given, the necessary equipment subcutaneous and intravenous medication be immediately available. The equipment needed — sterile ampoules of ephedrine, epinephrine, caffeine sodium benzoate, and intravenous outfit, salt solution and glucose, a gas machine with oxygn and carbon dioxide.

INDICATIONS FOR SPINAL ANESTHESIA.

Must be considered as relative. In a majority of cases in which the operative field lies below the diaphragm are suitable for this type of anesthesia; at present, operations above the diaphragm are not advisable. It is the ideal anesthetic for lower abdominal surgery, hysterectomies, prostatectomies, bladder cases, perineal operations, cesarean sections and numerous vaginal and rectal operations. According to Lundy,[2] "Spinal anesthesia continues to remain popular for preparing patients for operations on the large bowel."

In the acute abdomen this form of anesthesia becomes almost a matter of life or death. Morbidity is lessened, convalescence shortened, and the mortality rate lower.

Webb[3] says, "There is probably no operation where spinal anesthesia is more indicated than in intestinal obstruction. The marked re'axation of the abdominal wall together with the contraction and relative quietness of the intestine is a joy and a revelation to the surgeon accustomed to working with ballooned bowels constantly forcing themselves out of the abdomen." With "spinal" there is "absolute abdominal silence." There is less danger of pulmoary complications, especially where the patient has or recently has had a respiratory infection and it is the anesthetic par excellence for the patient with pulmonary tuberculosis.

Experience has shown that spinal anesthesia does not detrimentally alter the clinical course of patients suffering from an extreme urinary sepsis and is, therefore, an invaluable aid in urinary tract surgery.

"Spinal" is ideal in orthopedic operations on the lower extremities and in reduction of fractures of the femur with marked overriding, for it completely relaxes muscles and joints and shock is absent.

No diabetic patient today should have a major operation below the diaphragm under inhalation anesthesia.

Dehydration is not produced with this form of anesthesia which is an important factor in operation on cases of toxemia and eclampsia.

Shock is eliminated — the reflexes are blocked—tedious dissections are carried on with little if any change of condition.

According to Pitkin, "It is preferable in cardiacs, nephritics, alcoholics, addicts or patients suffering with primary or pernicious anemia."

Spinal anesthesia may be given to prepare a pneumonia patient for an emergency operation or to an influenza case. It is the anesthetic of choice for perforating gastric, duodenal or typhoid ulcers.

Contraindications are extreme-hypotension, infection on the back at the sites of puncture, positive blood Wassermann, cloudy spinal fluid and spinal deformities preventing proper puncture. It is not indicated in extremely nervous or otherwise uncontrollable patients; patients with convulsions or maniacal insane patients.

It is our opinion that spinal anesthesia should not be used where conduction or local anesthesia would do as well and it should not be used in operations consuming less than 20 minutes.

Pitkin: "I do not wish to advocate only the use of spinal anesthesia or to detract from the merits of inhalation anesthesia,

but I wish to emphasize that experience has taught me that with their use we can prevent the aftermath of operations—the nausea, vomiting, distension, illeus, acidosis, pneumonia and innumerable complications, which are directly or indirectly attributable to inhalation anesthesia."

Spinal anesthesia has come to stay, and it behooves us to learn all we can about it and to use it, not indiscriminately, but in properly selected cases. The measures of success achieved depends on the trained, intelligent cooperation of those surrounding the patient.

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DISCUSSION.

Dr. John C. Culley (Oxford): It has been a great pleasure to me to see the interest which has been aroused in spinal anesthesia in the last twelve months. The last issue of the American Journal of Surgery contained nine articles on spinal anesthesia. While those articles would rather muddy the water they bring out lots of points that should be considered. I want to congratulate Dr. Gardner on his paper. It has the three essentials of an excellent paper; it was brief, second, wise, and third, it was complete.

Those points he brought out with reference to technic there is no use of my reiterating. I simply want to mention the technic I use. The first thing is the preparation of the patient in acute cases. The patient should have the same preparation in acute cases as in other forms of procedure. I might say I am absolutely sold on spinal anesthesia, but not sold on any particular anesthetic. The technic that I have used with spinocain differs somewhat from the technic I have seen recommended. In acute cases I use sodium amytal, two capsules by rectum. In elective cases, I give one capsule at bedtime before the operation the next morning; the next morning two capsules of sodium amytal are administered about one hour before operation; along with the amytal, three-fourths grain of ephedrin. This brings out the point of how often I have used ephedrin. So far, I have been regular in using ephedrin in 501 cases reported at the last meeting, and I have since that time done about 175 cases and used ephedrin until I read this article in the American Journal of Surgery. I decided to leave off the ephedrin and I did in two cases, and both patients went into collapse and I had to administer vasomotor constrictors to bring my patients around. Three-fourths grain of ephedrin one hour before the operation, two capsules of sodium amytal about one hour before the operation, and about fifteen minutes before the patient is brought into the operating room, one-fourth grain of morphine. That brings the patient into the operating room in a quiet state.

I have drawn a little diagram to show the position I am placing the patient in today. The top picture should show the table perfectly level. You will notice that the hips being wider than the shoulders, the head is thrown downward and naturally the spine is in the Trendelenberg position.

The thing you are cautioned in doing with spinal anesthesia—remember that spinocain contains alcohol; it is of lighter specific gravity than spinal fluid. That being the case, if you inject it with your patient on the table with your table level, you are going to get the solution to float upward which is towards the coccyx, so the technic I have been using is to elevate the head of that table until the table shows an elevation of seven to ten degrees. If you will do that, and then look at your table with a ten degree elevation, your spine is almost level or a little elevated. I go on and make the injection just as Dr. Gardner described to you.

Dr. J. K. Avent (Grenada): I am going to discuss one phase of this question, that is, the technic of what to do after your patient begins to have the collapse. I always give the three-eighths or three-fourths grain of ephedrin two hours before anesthesia. I always use the spinocain because it has the ephedrin in it. If you notice your patient's pulse getting weak, give adrenalin, because it is the best thing you can find; it is a vaso-motor constrictor and will bring your patient back.

When you notice your patient getting weak, pale around the mouth, not noticing what you are doing, give adrenalin. If you can't get it into the veins inject it into the muscles and massage three or four minutes. You will get quick results.

It is a pretty good idea when you give spinal anesthesia to let some one else give it sometime and you watch the patient's pulse. I had never watched a pulse until a few days ago when I had a fractured femur, and gave spinocain, and through curiosity I watched the pulse.

I always give atropin because I think it helps the respiration all the way through. It has become a habit with me to give 1/100 grain of atropin with ¼ grain morphine within an hour before the operation. Aromatic spirts of ammonia is excellent. I let them have ice and ice water all through the operation. If they begin to get weak, give the aromatic spirits of ammonia. I

often take up the household ammonia and let them take a few whiffs of that. It gets their mind off of what is going on and relieves their anxiety.

If you have a patient that has a sense of touch, and they get pale and worried because of it, give them a few drops of ether. Quite often I give one or two cc. of ether hypodermatically.

Another thing, some of them have a very low respiration. Have your oxygen come through a glass tube and through a little water so you can tell how much you are giving your patient. Give them a little oxygen and it will work splendidly, especially when they have this weak condition. I have only had one patient to have any trouble with the heart following spinal anesthesia.

Dr. Lucies McGehee (Memphis, Tenn.): I thank you for the privilege of discussing this paper. I can add nothing to what Dr. Gardner has said as to the general value of spinal anesthesia. As Dr. Culley has said, I am sold on spinal anesthesia, but not entirely on the agent to be used.

I think I might contribute something to this discussion by getting away from generalities and other establish principles of selecting your patients and anesthetic and careful technique, and relate to you our experience in the Memphis General Hospital with the use of spinal anesthesia and certain conclusions we have come to with reference to its use. To begin with, about two years ago we began it, and the records recently showed there had been administered in the General Hospital by the surgical staff—I want to call your attention that that is by the head of the division down to the internes—men with limited experience in the use of spinal anesthesia—there have been close to 1500 cases in which spinal anesthesia was used. In the first 100 cases novocain was used without any untoward effects except that the anesthesia was too brief. At that time we were not using enough. We never had used in those cases 120 milligrams of novocain. About that time Pitkin's work was brought before the public, the use of spinocain. We used spinocain in 1000 cases. As Dr. Culley brought out, the technic is entirely different when you use spinocain instead of novocain. The specific gravity of the spinocain is less than that of the spinal fluid When it is injected it will tend to rise according to the position of the patient. It acts very much like the globule of air in a plain spirit level; in other words, depress that end and it will rise, and depress the other end and it will go the other way. Position is very important in the use of spinocain.

Our experience with spinocain shows there were marked variations in the blood pressure. It is true to a certain extent you can limit the degree of anesthesia by position of the patient, but for practical purposes you should have a skilled anesthetist, skilled in watching the effect of the blocking of the spinal rami. Even under those conditions there was marked falling of blood pressure. I find in 1000 cases there were three deaths; that is a pretty high percentage of deaths. These deaths, though, probably, would have occurred with any type of anesthesia, except one, possibly, of the deaths.

Dr. S. E. Field (Centerville): A few weeks ago I had the pleasure of visiting the Houston Clinic at Houston, Texas, and I would like to mention a point I saw out there in connection with spinal anesthesia. Dr. Stokes there is doing a great deal of his work with spinal anesthesia. Immediately after the injection of his anesthetic, with the table horizontal, he turns the patient over on his abdomen and leaves him in that position until he gets anesthetised as high as he wants or as low as he wants.

In some of our cases we prefer to get complete anesthesia. Sometimes we get it on one side and not on the other. I am wondering if we get proper dissemination of the agent; I am wondering if turning the patient over on the abdomen at times would have some effect on those cases in which we do not get perfect anesthesia.

Dr. A. E. Gordin (Jackson): I am very much sold on spinal anesthesia. I think I am one of the few doctors here who are. I think out of eight or ten surgeons only about three of us are using it to any great extent. I believe you can't be fanatical on spinal anesthesia as you can't be fanatical on other things. We have a good agent here we should use and should look for the contra-indications.

I don't know when I have heard a more conservative and well rounded paper than Dr. Gardner's paper.

We must get away from the prejudice against spinal anesthesia among the doctors; so many surgeons are using spinal anesthesia but saying definitely that if they were to be operated upon they would not have it used upon themselves. We must be confident that spinal anesthesia is not dangerous and the doctors are not afraid of it before we use it too much on our patients.

In 200 cases in which I have used it, I have had two cases of very severe headache, so severe this headache could not be relieved with morphine in less than a week or ten days. Some of the bad results we get are because we do not get complete anesthesia. My trouble is that in a few cases I have gotten no anesthesia and in some cases the anesthesia was over in 20 minutes or a half hour, before the operation was finished. I don't know yet how to regulate the time it takes. One of the great troubles I have had with

it has been in nervous patients. They are dead from the diaphragm down. They almost go into hysterics and amytal certainly prevents that to a great extent. In one or two cases where we have had respiratory failure following spinal anesthesia, we have had no trouble keeping the patient breathing with carbon dioxide administered during that time.

So far as the turning of the patient in any direction, I think that within about five or six minutes of the time you can inject the spinal anesthesia and scrub up again, it makes no difference how you turn your patient; the spinal anethetic is fixed and will not move.

In caesarean sections you do not get a relaxation. You get a uterine constriction just as much as you do with any other anesthetic. The uterus constricts right down to the size of your two fists in a caesarean section. Why that is I do not know.

I have nothing to add except to say I had one case where I am sure I got into the spinal canal and I could not get the spinal fluid. I have had some cases where I got blood on my needle, and I always remove the needle and reinsert it.

I wish to thank the essayist and I have enjoyed the discussion very much.

Dr. A. G. Payne (Greenville): I think Dr. Gardner selected the most important subject before surgery today. I want to endorse everything Dr. Gardner said in his paper. There are a good many points of experience I would like to go into this morning. Dr. Dickerson of McComb City last year brought to our attention the fallibility of spinal anesthesia, and that has been a great lesson to me and my fellows. For instance, you can't rely on any one mode of anaesthesia. Why should we rely on any one mode of anesthesia more than we do any other therapeutic measure in medicine today?

I recently had a case in which something went wrong. I was operating upon an immense fibroid tumor, under spinal anesthesia, and I had a hard time getting this fibroid delivered. During that time the puncture made into this fibroid had put considerable blood into the upper abdomen, and I had to resort to ether anaesthesia to get this blood from that portion of the abdomen that was unanesthetised. Of course, I had not intended to do any work at all in the upper abdomen. A question as to whether or not there was some bleeding point higher in the abdomen was the reason I was so anxious about this blood. Probably the blood wouldn't have done any harm. Now then, in the well organized hospital where you have the ether, the gas, and the local, and by the way I want to say here that the most universal anesthetic that we can use is the local anesthetic; there are so many places that we can use the local anesthetic where we are today using spinal or using general—so then, as to switching from one anesthetic to another, which we frequently have to do, if we are in a hospital where we have these measures to switch from one to another it is all right, but say you are not in a hospital or out some place operating where you don't have these facilities, then it makes it very hard altogether on the patient, and that is the one we should consider most.

Relative to the blood pressure, I have seen many times the blood pressure drop so low that we would begin to get uneasy about the patient and in those cases adrenalin brings up the blood pressure better than anything else.

Chairman T. P. Sparks, Jr. (Jackson): Spinal anesthesia in the last few years has become quite a success. I believe in it. I don't think that any surgeon who has ever used spinal anesthesia can resist the urge to use it again; its marvelous relaxation naturally tempts one to use it. Still, I think statistics show it is still a rather dangerous anesthetic. Statistics show, I think, the mortality runs about one in one thousand. That is a greater rate than we have with our inhalation anesthetics. As Dr. McCuskey said in his paper, they used spinal anesthesia in Rochester in about 11 per cent of their cases. I am sure here in the south some of us use it in about 99 per cent of our cases. Perhaps both of us are a little off. I believe spinal anesthesia should be used only in those cases where an inhalation anesthetic is contra-indicated. There are some other cases where we use spinal anesthesia instead of a general anesthesia, however, even though a general anesthesia is not contra-indicated, namely those cases where a complete relaxation will enable us to operate with more facility and thereby reduce our mortality rate. I think there have been statistics to show because of the facility with which a surgeon can operate the mortality rate is lowered under spinal anesthesia. I think in those cases it should be used.

One word about the use of ephedrin. There seems to be some hesitation to use it now in cases of low blood pressure. The worst reaction we get is not in our low blood pressure cases, but in the high blood pressure cases, and if we seek to use it in those cases there is where we are going to come to grief.

One word about the height of anesthesia. High anesthesia is usually obtained by high puncture but if one will inject the solution slowly and withdraw it and re-inject it several times, a relatively high anesthesia may be obtained even with a low puncture.

Dr. J. G. Gardner (closing): I wish to express to the gentlemen present my gratitude for the way you have discussed my paper, and I wish

especially to thank the visitor, Dr. McGehee, for his discussion of my paper.

It is impossible of course to write very much on spinal anaesthesia when one is limited to twenty minutes to the subject on which volumes might be written.

Referring to Dr. Culley's discussion of his results with sodium amytal, I agree in every detail with Dr. Culley in the use of this drug. We have used it in our work rather extensively. For the past few months we have been using Nembutal (Sodium Ethyl—[1-Methyl-Butyl]—Barbiturate) but have not used it in a sufficient number of cases to prove any superiority of this drug over sodium amytal. We have not used spinocain for the reason that novocain dissolved in the spinal fluid gives us most satisfactory results, and because the beds in the hospital are not adjustable so that we can keep the patients' heads lowered for the required time as suggested by Dr. Pitkin. It is very seldom in cases where you use 8 c.c. of the spinal fluid that you have failure of the anesthesia reaching as high as the diaphram. We use the 8 c.c. by withdrawing 4 c.c. of the spinal definite bony borders could be palpated around

The most unpleasant symtom we have in our cases of spinal anesthesia is nausea which we believe is best treated by increasing the Trendelenburg position and have the patient take deep inhalations. If this does not relieve the symptom more energetic treatment should be instituted, and as outlined in my paper, the most important thing is to begin treatment early. Adrenalin or ephedrin may be given intramuscularly in a slow drop, but in sudden drop it is important that prompt intravenous therapy be given.

We have no hesitancy in using ephedrin as suggested by Dr. Culley. His suggestion is good and it should be used as he advises.

AGRANULOCYTIC ANGINA.*

C. L. BROWN, M. D.,

NEW ORLEANS.

Agranulocytic angina or agranulocytosis was first described by Schultz in 1922. It is a most interesting symptom complex and a condition equally important to the general medical man and specialist. It can be defined as a very severe ulcerative angina, usually manifested by signs of an acute infection and associated with marked prostration, and extreme leukopenia with lack of granulocytes. Unfortunately, it has not been recognized in its beginning, therefore it has been accredited a mortality of around 96 per cent.

Since 1922 there have been perhaps 175 cases reported. In 1927 Kastlin collected 43 cases. Of this number, only three cases recovered. In 1928 Hueper collected 125 cases, and out of this group six cases recovered.

The diagnosis must rest on the composite clinical picture, and not on various symptoms. Without a complete blood picture, the diagnosis cannot be made. The blood changes are distinctive in the absolute reduction or complete disappearance of all granulocytes, polymorphonuclear neutrophils and eosinophils, from the circulating blood stream. The blood picture is that of a leukopenia with a decided increase in lymphocytes—sometimes 95 to 100. The coagulation time, as well as the bleeding time of the blood, is practically always normal. The blood platelets may be slightly diminished. The haemoglobin and red blood cells have been normal in the majority of cases. The white blood count has been the interesting and diagnostic factor. A leukopenia of 1200 to 1500 white blood cells per cu. mm. at the onset of the disease is usually the rule. In some cases, however, a much lower white cell count was noted when the first blood count was made As the disease progresses, the white cell count continues to fall, the lowest count recorded being 100 cells per cu. mm.

Cases of agranulocytic angina may occur in both sexes, the greater percentage occurring in women. The usual average age is about forty years. As a rule, the past histories in general are not significant. A period of general debility has been present in some cases. The onset is usually abrupt, with high fever and extreme prostration. The patient presents a picture of being very sick. The temperature may rise quickly to 102° to 104° and remain there. The patient develops a severe sore throat, rapid pulse, dysphagia, malaise and may have one or repeated chills. There may

*Read before the Louisiana State Medical Society, New Orleans, April 14-16.

be some dyspnea. A rash, herpes labialis, vomiting, diarrhea, abdominal pain and jaundice may occur, but are not constant symptoms, the latter named symptoms occurring in about 50 per cent of the cases. Less often there is headache and general muscle pain. Pharyngitis and stomatitis develops at the onset or within a day or two in all cases. The tongue becomes coated and the breath is fetid. The tonsils, pharynx, gums, tongue, mucous membrane of nose and larynx usually undergo ulceration and superficial necrosis. The tonsils are markedly hypertrophied and covered with either rapidly spreading ulcers or a dirty greyish membrane. A membrane is usually attached to the ulcerated areas and may extend to adjoining nonulcerative tissues. The membrane and necrotic tissue can easily be removed, and there is not a great deal of bleeding. Cultures from the mouth are negative for diphtheria bacilli. Various organisms have been described, the most common being organisms of Vincent (Vincent's angina), pyocyaneus bacillus and the usual mouth invaders. While there is not a generalized lymph node enlargement, the cervical lymph glands, as well as the submaxillary, may be slightly enlarged and tender. In addition to the above named ulcers, there may be ulceration of the anus, vagina, cervix and sometimes the skin. The liver and spleen may be palpably enlarged, sometimes associated with tenderness on palpation. In quite the majority of cases, the heart and lungs are negative.

The course of the disease is usually acute and very rapid. The patient, as a rule, grows worse and death results after a coma of two to seven days. A few cases have lived weeks and months, while a small percentage have gotten, seemingly, entirely well. The prostration and ulceration shows marked progress from day to day, or even from morning to night. The white blood count and differential shows definite change from hour to hour. It absolutely disappears in the majority of cases before death. As said before, the patient is severely ill from the onset. A state of exhaustion appears early showing a definite lack of physical resistance. Nourishment can be taken only with difficulty. Periods of temporary improvement have been noted but death occurs in more than ninety per cent of the cases.

The gross findings at autopsy are most interesting. In addition to the ulcerations of the oral cavity, rectum, vagina and skin, ulcerations are frequently seen in the esophagus, stomach and at all levels of the intestinal tract. The lesions have little surrounding inflammatory reaction involving only the mucous membrane. Clotted blood has been noted in the stomach and intestine. Kastlin reports that in one of his cases, ulceration of the heart valve was found. A broncho-pneumonia is usually present. Examining the liver grossly, the surface shows some cloudy swelling. Small hemorrhages are usually associated with the bowel ulcerations and may be noticed on the abdominal viscera, as well as on the surfaces of the lung. On gross section the spleen, which also may be enlarged, presents a pulp which is firm and dark red. As a rule, the bone marrow is usually pinkish or red, but sometimes it is fatty in appearance. Grossly, the kidneys do not show anything of note.

On microscopic examination, the necrotic areas show clumps of fibrin, bacteria and red blood cells, while beyond the necrosis, there is not any inflammatory cell reaction, except an occasional lymphocyte, endothelial and plasma cells. There is noted in the mouth ulcers a peculiar lack of cellular response. The necrotic portion is sharply bordered by edematous tissue. Ulcerations of other locations also show a similar lack of cellular reaction. The blood vessels are most of the time thrombosed and contain fibrinous plugs.

Kastlin, of Pittsburg, was the first to report the pneumonic lesion. Since then other writers, among them Rose and Hauser, Heuper and O'Connor and Windham have

noted this. The alveolar spaces of the consolidated portion, (you will recall that I have stated that most cases terminated in a bronchial pneumonia) are completely filled with a fibrinous and hemorrhagic exudate, with practically no inflammatory cell reaction. Polymorphonuclear leukocytes are rarely present, but occasionally lymphocytes and endothelial cells are deposited on the edge of the plugs of fibrin. The fibrin forms a compact network, often more dense at the margin. Under the microscope, the bone marrow shows almost a total absence of white blood elements. The sections appear quite "cell poor." There are occasional clump of endothelial cells. There is in the typical case only an occasional granular cell present.

The lymphoid centers of the spleen, under microscopic examination, are less prominent than usual, while the reticulo-endothelial structure of the pulp shows marked proliferation. The lymph nodes show a decrease in lymphoid germinal centers and prominence of endothelial cells. Under the lens the liver shows a cloudy swelling. There is also evidence of a slight perivascular lymphoid infiltration.

The kidneys, when examined under the microscope, show hemorrhages of the renal pelvis, a cloudy swelling, and sometimes lymphoid collections about the glomeruli.

Agranulocytic angina must be differentiated from pernicious anemia; acute poisoning; severe secondary anemia; aleukemic leukemia; sepsis. It is diagnosed from:

(1). Pernicious anemia by the extreme prostration, angina and the absence of the typical blood picture of a low red count, high color index and usually normal white blood count.

(2). Poisons, such as arsenic, benzon, thorium and the roentgen rays, may produce leukopenia with granular cell decrease. However, the poisons, in general, may be ruled out by a careful history of the case.

(3). Severe secondary anemia by the history, and the absence of the blood picture of a uniform definite decrease in both red and white blood cells with a normal differential.

(4). Aleukemic leukemia by the blood picture, symptoms and absence of generalized increasing enlargement of the lymph glands.

(5). Sepsis by history, physical findings and blood picture.

In the treatment of agranulocytic angina, there is no uniformity of opinion as to the efficacy of therapy. Personally, we believe there is only one form of treatment, and that is repeated blood transfusions. It has been our good fortune to see two cases recover by the above treatment, while on the other hand, we have seen some four or six cases in which it did not do any good. L. Fisher reports a case successfully treated with immuno-transfusions. His deduction was that, since the disease is of an infectious origin, that the serum from a recovered or convalescent patient might contain immune bodies. Intravenous neo-salvarsan and stimulating doses of roentgen ray have been used in an attempt to stimulate the bone marrow function.

Local treatment is directed toward alleviation of sore throat and pain by frequent gargles and various antiseptic applications. Flower's solution and emetine hydrochloride or salvarsan and neo-salvarsan, a 10 per cent solution, freshly prepared in glycerine, are suggested for cases showing Vincent's infection.

I would like to present two cases, one of which is particularly typical. They are as follows:

CASE REPORTS.

Case 1. Mrs. L., white, female, aged forty-two years. Chief Complaint: Painful throat and swelling of right side of neck. Present Illness: Trouble began about nine days ago, when the patient awoke in the morning to find her throat very sore and the right side of her neck, just beneath the mandible, red, swollen, and painful. She was unable the swallow without increasing the pain, and to talk was difficult. She stated that she felt feverish, generally ill and, to give her exact words, that she was "completely knocked out." Her condition continued to get worse and she called her physician, who advised her to go to the hospital.

This she did on June 12, 1930 at 5:40 p. m. Past History: Patient had tonsils removed twenty-one years ago. She had had occasional naso-pharyngitis during the winter months. Family History: Negative. Physical Examination: Physical examination revealed a fairly well developed, well nourished white female, who appeared very sick. Head: Throat was red and inflamed. Slight ulceration on the left side of the tonsil fossa. Neck: Slight swelling and tenderness on right side. The anterior cervical glands on the right side were swollen, hard and slightly tender. Chest: No change in voice or breath sounds, and no rales. Chest apparently negative. Heart: No murmurs, pulse rapid. Abdomen: No palpable masses, tenderness or rigidity. Extremities: Negative. Temperature: 101°. Urinalysis: Negative, except a slight trace of indican. Blood Picture: June 12, 1930. Erythrocytes: 4,170,000. Hemoglobin 79 per cent, leukocytes 3,750, small lymphocytes 80, neutrophils 20. June 15, 1930 erythrocytes 4,475,000; hemoglobin 70 per cent; leukocytes 2,200; small leukocytes 87, large lymphocytes 10; neutrophils 3. Blood culture on June 16, 1930 was negative after seventy-two hours. Smear from tonsil area showed occasional pus cells, epithelial cells, few streptococci, staphylococci and Vincent's bacilli. A diagnosis was made at this time of agranulocytic angina, and on June 17, 1930 blood transfusion by the head method was performed. Three hundred c.c. of pure blood were given the patient.

Case 1.

Date	WBCS	Polys per cent	Myelo per cent
June 21	3,750	18	0
June 23	5,000	16	0
June 24	5,750	20	0
June 25	6,750	28	0
June 28	7,000	67	0
Oct. 17	2,700	12	0
Oct. 23	3,250	14	9
Nov. 1	2,125	0	12
Nov. 2	2,250	0	5
Nov. 6	1,850	0	20

The important blood findings are shown in the above chart.

The patient was much improved; her temperature subsided; throat condition practically cleared up, and, consequently, she was allowed to go home on June 28, 1930.

During the interval from June 30 to about October 1, 1930, the patient was able to be up and about the home with very little discomfort. Shortly after this, there developed ulcerations on her fingers, back and in her nose. She returned to the hospital on October 9, 1930 for blood transfusion. At this time, 300 c.c. of whole blood were given her by means of the direct method. There was moderate reaction. Patient was allowed to go home on October 10, 1930. From this time on the patient was most uncomfortable; she was unable to retain her food, in fact, it was most difficult to get her to take anything. She had a daily temperature, and ulcers appeared again in the tonsil fossa, mucous membrane of the mouth, nose fingers, elbows, back, and even the vagina and anus.

On October 17, 1930 she was admitted to the hospital for a third blood transfusion. Three hundred c.c. of pure blood were given her by the direct method. She was allowed to go home the following day. Patient got progressively worse, most uncomfortable.

Patient was admitted on October 23, 1930, and 300 c.c. of pure blood were given her by the direct method. Reaction most severe, temperature going to 106°, and gradually returning to around 100. She was allowed to go home the following morning. During the following week, the patient was desperately ill, gradually growing weaker day by day. At this time, it was practically impossible for her to retain any food.

On November 1, 1930, 350 c.c. of pure blood were given her by direct method. You will note that, regardless of our continued blood transfusions, the patient did not respond. The reaction was most severe. On November 7, 1930, antistreptococci serum was given. There was a marked reaction, and on this same day, patient complained of a catch in right side on cought and deep respiration. Few rales were heard in the axillary line, also tubular breathing was heard over the back. The patient was very weak, pulse irregular, and semi-conscious. On November 8, 1930 friction rub, coarse rales, tubular breathing over base of right lung—posteriorly and in axillary line. Definitely pneumonia. From this time on until the end, which came at four o'clock on November 10, 1930, the patient did not regain consciousness.

AUTOPSY.

External Examination: Body is that of an adult female about 45 years of age. It is well developed and fairly well nourished, weighing about 120 pounds and measuring about 5 feet 9 inches in length. Postmortem rigidity is absent. Postmorten discoloration is present around the base of the neck and over the dependent portions of the body. The skin is warm, pliable, and over the lower abdomen shows evidence of past pregnancies. There are also ulcerations located in various portions of the body, around the base of the neck, posteriorly over the buttocks and on the sides of the legs and back. These ulcerations vary in size from pin point to 3 cms in diameter and they have a scaling crust over the surface. Others show small papules and around the base of the

neck are small reddish spots. (Only the relevant data are included in the autopsy report).

Upon opening the pleural cavity, both cavities are partially filled with sanguinous fluid. The right pleural cavity shows about 1000 c.c. of this fluid while the left shows about 250 c.c. The right lung shows the upper portion of the upper lobe to be solidified and a purplish red color. The rest of the lobe is light pink and crepitant with the exception of the posterior portion of the lower lobe which is purplish red and solid. There is adhered to the outer surface a moderate amount of yellowish purulent exudate. The left lobe shows small abscesses of the surface of the upper lobe attaching itself to the thoracic wall in the region of the second rib near the midline. The posterior portions of the lower left lobe is collapsed and purplish red in color. The rest of the lung is light pink and crepitant. Upon opening the pericardial cavity the pericardium is found to be smooth and glistening. There is no free fluid in the pericardial cavity. The heart is enlarged and dilated. It measures 14 cms from the base to apex and 12 cm in width at the base. At the anterior surface near the base, there is a white sac measuring 1 cm in diameter. The right auricle is found to be distended with blood. The liver is 25 cms in width and 28 cms in length and 10 cms in thickness at the right dome. Its outer surface is smooth and glistening and of a reddish brown color. There is a small yellow pinpoint area in the left lobe which is 1 mm in diameter. It offers little resistance to the knife. It is mottled yellowish pink in color, the predominating color being yellow. The spleen is 1½ times its normal size. It is soft and pliable in consistency. Its outer surface is purplish red in color. On incision one finds that the cut surface offers little resistance to the knife. The pulps scrape off easily and there is very little fibrosis. The kidneys—The right kidney is of a normal size and shape, purplish red in color. The capsule strips easily, leaving a glistening, slightly granular surface. The color of the surface is mottled yellow and pink. On incision the surface shows that the organ is not markedly fibrotic. The cortex was 1 cm in diameter and easily differentiated from the medulla. The blood vessels are congested and parenchyma swollen. The adrenals are not abnormal. The left kidney is slightly larger than normal and presents a picture similar to that of the right kidney just described. The internal genitalia shows that the tubes are markedly congested. Both ovaries are fibrotic. The uterus was of a normal size and shape for a nulliparous one. The mesenteric lymph nodes are slightly congested, but not enlarged. The heart—The organ is 15 cms long, 12 cms wide, and 5 cms thick. The outer surface is somewhat irregular and glistening. In a large extent it is covered by a layer of fat which is of a slight yellow color. Other areas can be seen where the musculature is in evidence. Through the fat on one surface runs the coronary vessel, while on the other surface they are not visible. The wall of both atria is about 4 mms thick. The right ventricular wall is 1½ cms thick, while the left ventricular musculature is 2 cms thick. On incision and observation of the musculature, one finds that it is of a very light brownish red color and is not friable in consistency. The inner surface is smooth and glistening and in the ventricles, there are very definite papillary muscles from which are extending chorda tendonae. On examination the valves show no evidence of sclerotic changes or of growth. The sligh portion of the aorta which is present is 2 mms thick, but throughout shows no sclerotic changes.

Gross Anatomical Diagnosis: Toxic myocarditis; lobular pneumonia; edema of the lungs; pleurisy with effusion on the right side; abscess of the lung on the left side; dilation of the heart; fatty degeneration of the liver; acute toxic splenitis; acute toxic nephritis; some type of ulcerative dermatitis.

Microscopic Diagnosis: Heart—Toxic degeneration of muscle fibers.

Lung—Edema of lungs; peribronchial infiltration of lymphocytes, heart failure cells in air sacs; multiple abscesses, no neutrophiles in abscesses.

Liver—Albuminous and fatty degeneration, more marked centrally; beginning cirrhosis; peripertal small lymphocytic infiltration.

Spleen—Slight fibrosis, moderate blood pigment with large phagocytics; no neutrophiles found.

Kidney—Acute toxic glomerulo-tubular nephritis; congestion of some of the blood vessels.

Culture from heart blood shows Streptococcus hemolyticus.

Case 2: Mrs. J., white female, aged fifty-four years. Admitted to Touro Infirmary in ambulance on May 8, 1928. Chief Complaint: Severe sore throat. Present Illness: About a week ago, patient became ill with sore throat and fever up to 103.2 degrees. Since then she has continued with sore throat and fever. No vomiting, but was nauseated and could not eat. Diarrhea. Past Illness: Patient has been in poor health for about two years, especially last six months. She has lost about thirty pounds. Does not feel like eating. Family History: Negative. Physical Examination: General: An emaciated, quite prostrated, very sick, middle-aged woman. Dehydrated. Ears, nose, eyes and mouth negative. The right tonsil was enlarged, fiery red. There was an area about 1 cm. square, which was greyish white, and when sponged and swabbed out revealed a cavity about

2 cm. deep. There was another small greyish area on soft palate, just to the right of uvula. Heart and lungs negative. Abdomen negative; spleen not palpable. Extremities negative. Clinical findings: May 8, 1928: Erythrocytes 4,100,000; leukocytes 520; no neutrophils on smear. On May 9, leukocytes 575; no neutrophils.

Case 2.

Date	WBCS	Polys per cent
May 9	575	0
May 10	380	0
May 11	920	Few
May 12	1,500	36
May 13	2,000	36
May 14	2,800	....
May 15	3,750	62
May 16	5,900	63
May 17	4,100	50

Daily counts from May 18-25 showed the white cells varying from 2,900 to 4,260 with the percentage of poly-morphonuclears ranging from 38-50.

The above chart shows the important features of daily blood count.

Special Examinations: Fusiform bacilli and spirilla found in large numbers in throat smear. Urinalysis: Negative.

Wassermann: Negative. Blood Culture: Negative. Diagnosis: Agranulocytic angina.

Having arrived at the above diagnosis, treatment to relieve the local condition was instituted, and blood transfusion was performed in which the patient received 500 c.c. of whole blood by the direct method on May 10, 1928. Two transfusions followed: On May 12, 1928—500 c.c. blood, and May 21, 1928—250 c.c. blood.

The following is the progress record in this case, which is of particular interest in that, if followed carefully, you will note the gradual improvement in the patient's condition to the point where she was discharged as apparently well on May 26, 1928.

Progress Record: May 8, 1928—Patient is admitted apparently quite weak and prostrated. She has a sore throat, red, and slough on right tonsil and on soft palate on right side. Temperature 102-103. Duration of symptoms, one week. Before that, weak and nervous for months, at least six months.

May 9, 1928—Patient's condition about the same. Nourishes fairly well. Temperature about the same. Vincent's organism found in smear in large numbers. Blood pressure 126/58. There was observed an erythematous macular eruption on right arm and on hip, which has spread over back, both hips and arms.

May 10, 1928—Pulse 120. Blood pressure 130/70. Heart sounds are fair, no murmur. Lungs, clear. Abdomen, no distention, no pain on pressure, looks pale, and the rash has decreased some. Anterior axillary palpable—no other glandular enlargements.

May 11, 1928—Pulse 110, radial; respiration fair volume. Heart sound fair. Blood pressure 120/70.

May 12, 1928—Pulse 100. Blood pressure 120/80. Heart sounds are fair. Lungs, clear. Has some pain in epigastrium and lower sternum, but nothing to account for the general condition of patient.

May 13, 1928—Pulse 100, regular. Blood pressure 120/70. Heart sounds, good. No murmur and friction rubs. No distention of abdomen. No pain on pressure. Patient feels better than yesterday, and on whole condition is most encouraging.

May 26, 1928—Patient has shown steady clinical improvement. Discharged, apparently well.

We heard from this patient from time to time during the following eighteen months. She remained well, in fact, during the first twelve months following this illness, the patient returned to New Orleans about every three months for a total leukocytic count, and each time it was within the normal range. This would indicate that we could consider the patient as cured.

SUMMARY.

In a review of the records of Charity Hospital, Touro Infirmary and Baptist Hospital, of New Orleans, eleven cases were found with a diagnosis of agranulocytic angina, two cases in 1927, two in 1928, one in 1929 and six in 1930. Two of the cases, or 18 per cent, occurred in negroes, and two of the patients were males. The average age was 36.8 years, the oldest being 70 years and the youngest 4 years. The average stay in the hospital was 17 days with extremes of one and 75 days. The patient who was hospitalized for 75 days was suffering from other medical conditions. There were ulcerated lesions in two of the cases. The following areas of ulceration were noted in some one of the nine other cases: Tonsils, pharynx, gums, oral mucosa, soft palate, epiglottis, uvula, arytenoid cartilage, base of tongue, labia and vagina. Smears of the

lesions showed the usual organisms found. One of the cases followed an acute alcoholism. The symptoms were not absolutely typical in all of the cases, but the blood pictures were characteristic of agranulocytosis. One case had a 100 per cent lymphocytic differential count.

DISCUSSION.

Dr. S. M. Blackshear (New Orleans): Agranulocytic angina, one of our more recent pathological arrivals, is a rare disease, which is fortunate on the one hand and unfortunate on the other, for we do not have the opportunity of concentrated study on a series of cases.

Our limited experience in treating this malady was favored with such satisfactory results in employing whole blood transfusion, that we feel that this is the most logical way of treating this disease. In my opinion, the blood dyscrasia is the most important phase of the disease, and therefore I feel that we should fight the disease through the blood stream.

The Vincent's angina ulcers in the throat may be treated locally, but whole blood transfusion is the only therapeutic agent that I believe any faith can be pinned on.

Dr. F. M. Johns (New Orleans): I have had the pleasure of making several examinations on the patient whom Dr. Brown has reported, and I can testify to the apparent cure. In size, number, shape and staining reaction the white cells are apparently normal and complete regeneration has apparently occurred.

This is a very interesting disease in which complete destruction of one class or type of body cell occurs. It appears to follow exactly the same process which occurs when certain chemicals such as benzol, are given which have a destructive effect on the leukocytes and myelocytis in the bone marrow. This precedes the angina, and apparently has no definite connection with the bacterial flora present in the throat.

There are cases on record in which we have an agranulocytosis without any angina. I followed one such patient last summer over a period of three months. He had a complete absence of neutrophils, eosinophils and basophils, but there was no history of a previous angina, and there was no such complication up until death ensued. I prefer to look upon the angina as a secondary infection. The granulocytes we know play a most important part in fighting off any sort of disease process, and when they are absent there is no protection against infection. Certain areas of the body are at all times heavily charged with various sorts of bacteria, such as the oral cavity, the rectum, the vagina and similar structures. Sooner or later infection is bound to occur and particularly when the natural defensive mechanism is lost. In such cases as this the best prophylaxis is the preservation of the integrily of the mucous membrane.

Two weeks ago I saw a patient with a terminal broncho-pneumonia in whom there was no evidence whatsoever of any granulocytes. She died within 28 hours with no evidence of angina, but the leukocytes went down to a total of 500.

If we are dealing with an agranulcytosis we must preserve the integrity of all mucous membranes, and use every possible measure to promote regeneration of the bone marrow. If there is any myeloid tissue left there is some possibility of regeneration if the patient lives long enough to allow such to take place.

Dr. M. P. Boebinger (New Orleans): I have seen several cases with a fatal issue in which I was able to identify the fusiform bacillus by slide examination. Culture is not satisfactory in this type of case because the report is too late in coming. There is no know media today which will grow Vincent's angina. A superficial smear may give negative results, but if you remove tissue by the curette or by forceps you will bring the organisms with it and your diagnosis is made without difficulty.

I might remark, as a matter of interest, that I recently saw a most unusual case in which the leukocyte count went up from a few thousand to 200,000 at the time of death.

As to the use of whole blood, I think that treatment is well combined with small doses of salvarsan. In treating Vincent's angina, I use the curette or forceps, as I have explained, to get my diagnosis, then use a solution of perborate or peroxide or something similar, followed with a 50 per cent solution of salvarsan. I see the patients 3 or 4 times a day for the application, and if results are not prompt, I employ another technique, the introduction of salvarsan into the vein or tissue by needle, which practically always gives results.

Dr. A. A. Landry (Plaquemine, La.): I recently found a report of a case by Dr. Stewart Roberts of Atlanta, which seemed to prove that the etiologic factor in these instances is a failure of the bone marrow element to produce granulocytic cells. Why it fails to produce this special blood cell, while it continues to produce other blood cells, we do not know. The throat symptoms are secondary to the systemic disease caused by the invasion of the organisms which is possible because a granulocytic defense is not available. Blood transfusion is the logical treatment in view of the etiology. It is suggested that roentgen ray treatment may stimulate the bone marrow to

resume its normal function, but this is not established. We cannot say that any special organism is responsible for the disease, for blood cultures have evidenced many known types. The crux of the whole matter is the endeavor to discover what is responsible for the break-down of the bone marrow to produce the granulocytes.

THE ETIOLOGY AND PROGNOSIS OF SINUSITIS.*

JOHN B. GOOCH, M. D.,

NEW ORLEANS.

In recent years, the spotlight of medical attention has been turned to the sinuses as foci of infection responsible for all kinds of constitutional disturbances, and with modern methods of diagnosis, notably the roentgen ray, we are discovering that a surprisingly large percentage of all patients have some form of sinus infection. In spite of the vast amount of work and research that has been done, there is yet much to be desired in the clearing up of chronic cases and so it would seem only logical to devote more of our time to their prevention.

There is probably no phase of medicine that it so misunderstood by both the profession and the laity. Most people, including some physicians, have the idea that sinusitis is essentially an incurable disease, almost comparable to cancer, requiring repeated operative procedures with very little, if any, hope for improvement. Patients with nasal symptoms are actually afraid to go to a rhinologist for fear he will pronounce their condition sinusitis, which in their mind, would be almost equivalent to condemning them to a state of semi-invalidism for life.

Hence it is the purpose of this paper to discuss in a general way the etiology of sinusitis, attempting to show how it might be prevented, and to give some idea as to its course and prognosis.

With the exception of those cases of dental origin, sinusitis always begins as a head cold, and, conversely, every head cold has the potentiality of developing into a sinus infection.

The common head cold (coryza or acute rhinitis), is defined as an acute inflammation of the mucous membrane of the nose and, in most instances, there is some involvement as well of that lining the nasal accessory cavities. While no specific micro-organism has been isolated, it is fairly definitely settled that colds are due to a filtrable virus. However, the complications are due to secondary invasion by the bacteria flora normally found in the nose and to which healthy mucous membrane is an effective barrier; the Micrococcus catarrhalis, the influenza bacillus, Bacillus mucosus capsularis and the various types of staphlococci, streptococci and pneumococci. The contributory or exciting factors are well known though not sufficiently stressed: fatigue, exposure, dissipation, improper clothing, lack of exercise, improper ventilation, overheating; general physical conditions, malnutrition, vitamine deficiency, disturbances of the gastro-intestinal tract; and, notably local conditions as deflected septums, hypertrophied turbinates, diseased tonsils and adenoids.

The course of the common cold is so well known that I shall not describe it, but the question naturally arises, "How can we tell when a cold has developed into an acute sinusitis?" Head colds accompanied by unusually severe symptoms, nasal blockage and profuse discharge, that persist longer than from three to seven days, are complicated by a sinus infection. When headache, fever, a sensation of weight in the head and tenderness over the sinuses develops, these cavities not only are infected, but contain pus under pressure.

The sinuses are normally sterile cavities lined with ciliated columnar epithelium containing numerous mucous glands. In the event of an infection, these glands produce an enormous quantity of mucous and muco-purulent material. Since, with the exception of the frontal, the ostia of the sinuses are placed above the floor, this se-

* Read before Orleans Parish Medical Society June 8, 1931.

cretion can be expelled, when the patient is in the erect position, only by ciliary action. If these ostia are blocked by a deflection septum or by swelling of the nasal mucous membrane, the sinuses are unable to empty themselves. The longer the secretion remains in the sinuses and the more frequently acute attacks are repeated, the greater is the damage done to the highly specialized epithelium. A viscious circle is instituted and once the cilia are destroyed the normal defensive mechanism of the sinuses is lost and cannot be restored.

The prophylaxis of sinusitis therefore consists in the prophylaxis of head colds and in the early treatment of acute cases.

Patients who are unusually susceptible to colds should be examined by a rhinologist. If there is any sinus condition it should be given appropriate treatment, and the patient warned of the necessity of turning promptly in the event of an acute flare up. If the sinuses are clear, infection may be prevented by attention to local conditions, the removal of diseased tonsils and adenoids or the resection of a deflected septum. Contributory factors should be carefully checked over by the family physician, and everything possible done to reduce or eliminate them. This would include the building up of the debilitated patient, the administration of appropriate vitamines and hormones, advice as to exercise and the proper adjustment of heat, clothing and ventilation.

There is considerable discussion as to the value of vaccines; it is claimed that some patients are not benefited by their use; that if colds are due to a filtrable virus and vaccines are only for the secondary invaders, they can be of no value in the prevention of colds, but we should not lose sight of the fact that the distressing complications of colds are due to these very same secondary invaders. Even if vaccines have only a fraction of the 70 per cent effectiveness claimed for them, they can do little, if any harm, and they are of inestimable value to those cases that they do help.

Patients should be made to realize that the form of sinusitis of which they have heard so much as necessitating prolonged treatment and repeated operations is the result of neglecting early treatment. If the general practitioner would realize that acute sinisitis demands early treatment just as urgently as a case of acute gonorrheal urethritus, there would be a great deal fewer cases of chronic sinusitis. As in a Neisserian infection, as soon as the posterior urethra and the prostate become involved the prognosis is made infinitely worse, so in the case of an acute rhinitis once the infection has spread to, and becomes embedded in, the delicate mucous membranes of the sinuses it is much more difficult to eradicate. If any, the urologist has the advantage over the rhinologist, because he can at least massage the prostate and so express the products of infection, while the rhinologist must depend almost exclusively on ventilation and drainage.

I once heard a patient say that her child's tonsils and adenoids had been removed, but that the sinuses were only drained but not taken out. This idea is more generally shared than we realize and may account for the popular disappointment at the results of sinus surgery. The laity should be made to understand that the sinuses are not appendages, like the tonsils or the appendix, but rigid bony cavities which cannot be removed or obliterated. In general surgery the principle followed in dealing with an infected sinus is to remove all epithedial tissue and to allow it to heal by granulation from the bottom up. Unfortunately this principle cannot be followed in the nasal accessory sinuses.

No surgical procedures thus far devised can restore normal physiological function to a diseased sinus; intra-nasal openings have for their object the substitution of gravity drainage for drainage by ciliary action and radical operations the removal of all diseased epithelium with the hope that it will be replaced by normal tissue which, as we know only too well from ex-

perience, is seldom equal to the original healthy mucosa and is less resistant to infection.

Operations on the sinuses often have to be repeated, and naturally so, because the rhinologist strives to be as conservative as possible and to exhaust all simple measures when practical before resorting to radical operations. It must also be borne in mind that there are eight sinuses in all, four to a side, and in addition, the ethmoid alone is made up of from four to twenty separate, distinct cells. It is possible for one sinus to be infected and to be cleared up by treatment, or operation, and then later another group to become involved. No one complains of having to go back to a dentist to have some more work done within six months or a year after his first visit, yet we see a large number of patients trying to ascribe a sinus infection to some previous operative procedure, which might have been done on an entirely different group of sinuses.

In conclusion, any condition that is so generally prevalent, so resistant to treatment, and so crippling in its general constitutional effects as sinusitis demands our best efforts at prophylaxis. This can be done by considering every head cold as a potential sinusitis and by striving to prevent or lessen the severity and recurrence of head colds, and secondly, by urging patients to report for treatment in the acute stage so that the infection may be controlled before the histology of the highly specialized nasal mucous membrane has been permanenty altered.

DISCUSSION.

Dr. J. R. Hume (New Orleans): Ten years ago, sinusitus was considered to depend in most instances for its treatment upon surgery. Our literature was largely devoted to surgical technic. We have not improved greatly upon the technic developed during this period. Following this, diagnosis, occupied the spotlight and with the improved technic of the radiologist and the more general use of the naso-pharyngoscope, we were informed with a reasonable degree of accuracy, the changes that had taken place in the sinus mucosa. More recently the major attention is being paid to its etiology, its prevention and its relation to general medicine.

At last our investigations seem to be saner and more likely to bring gratifying results. It has been determined that the sinus mucosa is very resistant to infection. What are the factors that lower resistance and prevent bacterial invasion? Is it faulty diet, an endocrine imbalance or an allergic manifestation? These are the questions that must be answered by the otolaryngologist with the help of his confreres in other lines.

There is no doubt that we otolarnygologists have had our faults in regard to sinus disease and are openly negligent in research and etiology. No doubt such men as Kistner, Dean, Carmody, Shurly and others who have worked on etiology and pathology in regard to bacteriology, in relation to general constitutional disturbances, and the relationship of allergic conditions brought out so ably by workers in Washington University, have shown that many factors have and are yet to be discovered in the etiology of sinusitis. We know allergic conditions operate in the etiology of sinus disease. We know that sinus disease aggravates allergic disturbances and vice versa. We know that in addition to many constitutional disturbances which make up the basis for our sinus infections in which we have been terribly negligent, there are endocrine and other factors which we must understand before the book of etiology will be completed. We know that constitutional disturbances as gastric disturbances, allergy, endocrine, vitamine, etc., are the fundamental factors and the physiological defects of the nose such as deviated septum, etc., are the predisposing causes of sinus disease.

We know that there are many other causes which the essayist has not talked about under general yet specific causes. We know that many of our bone pathology cases are tubercular or syphilitic sinusitis, even some are malignant.

Because of our lack of etiology in sinusitis, we resort to resection of the sputum and other measures of constructive surgery later on, radical surgery. By that time the patient is disgusted and consequently the general attitude is that, once operated, the patient must be reported ten or twelve times.

In conclusion, the one thing I would like to urge is that we devote as much research toward etiology as towards therapy. When we know etiology, therapy is a lot more simple.

Dr. John B. Gooch (closing): I had hoped that the men doing general practice would take part in the discussion for the paper was written especially for them. I have tried to stress the importance of the general practitioner paying more attention to the nose, as nose cases usually go to them first. Most cases of acute sinusitis clear up spontaneously, but it is that small percentage that does not and continues on to the subacute or chronic stage that causes so much trouble later.

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THE NEW OFFICERS OF THE LOUISIANA STATE MEDICAL SOCIETY.

The recent business meeting of the Louisiana State Medical Society was completed by the installation of Dr. Roy B. Harrison as President for the coming year. Dr. Harrison needs no introduction to the physicians of Louisiana. His wide acquaintance, his knowledge of economic and scientific medicine and his known gifts as an executive, give to him certain attributes which undoubtedly will make Dr. Harrison one of the most successful presidents the State Medical Society has ever had. To Dr. Harrison the Journal extends felicitations and congratulations.

The new officers that were elected to the organization were first the President-Elect, Dr. C. A. Weiss of Baton Rouge. Dr. Weiss has been a practitioner of medicine in the State of Louisiana ever since his graduation from Tulane University of Louisiana in 1900. Shortly after starting practice he decided to specialize in diseases of the eye, ear, nose and throat, and it is as a specialist in this branch of medicine that Dr. Weiss has obtained his greatest reputation. He has been an active contributor to the Section on Eye, Ear, Nose and Throat, and in 1924 was honored with the appointment as Chairman of this particular Section. His reputation throughout the State as an ophthalmologist and otolaryngologist, and as a leader in organized medicine is a distinguished one. In the latter capacity he has been a delegate to the State Society for a number of years; he has been Chairman of the Committee on the Care of the Indigent Physician since 1922; Chairman of the Committee on Arrangements for the 1928 Annual Meeting in Baton Rouge; from 1925 to 1928 Dr. Weiss was Councilor of the Sixth District; he has been as well both Second and First Vice-President of the State Society, and this year and the approaching year will be Chairman of the Committee on Public Policy and Legislation. Dr. Weiss well merits the honor that has been bestowed upon him. He has been an unselfish laborer and worker for the ideals and high purposes of the Medical Society.

Dr. J. T. Nix of New Orleans was elected First Vice-President. Dr. Nix is one of the best known surgeons in New Orleans. He has recently been made one of the Professors of Surgery in the New Louisiana State Medical School, an index of the respect with which he is held in his home city.

For the position of Second Vice-President Dr. C. M. Horton of Franklin was honored. Dr. Horton has been active for many years in the State Medical Society,

and is a practitioner who has obtained a splendid reputation in his community.

For Third Vice-President Dr. W. P. Butler of Shreveport was elected by the House of Delegates. For some years Dr. Butler has been a delegate in the House and he has been active as well in the medical affairs of the Shreveport Medical Society.

Every member of the State Medical Society is acquainted with the genial, capable, and efficient re-elected Secretary-Treasurer, Dr. P. T. Talbot, who has held office now for some fourteen years. It is our hope that Dr. Talbot will hold this office for at least fourteen years more.

The Councilors of the First and Second Districts, Dr. H. E. Bernadas and Dr. D. N. Silverman of New Orleans, were re-elected. Their re-election is indicative of the high esteem with which they are held in their districts. The Councilor of the Fourth District, Dr. W. H. Browning of Shreveport, is a very recent graduate of the Tulane Medical School. He has, by his good common sense, and his knowledge of medicine, obtained a standing which is unusual for one so recently graduated. Dr. J. B. Vaughan of Monroe was elected as the Councilor of the Fifth District. Dr. Vaughan is well known to the doctors of the State to whom it will be obvious why he was elected to this position of honor and responsibility.

Dr. J. J. Ayo of Raceland has made such a splendid record as a just and impartial parliamentarian that there is no one in the State likely to succeed him as long as he wishes to hold the position as Speaker of the House of Delegates.

The list of Committees that were elected will appear in the report of the House of Delegates of the State Medical Society.

THE MISSISSIPPI STATE MEDICAL ASSOCIATION OFFICERS.

To the new officers of the Mississippi State Medical Association the New Orleans Medical and Surgical Journal extends warm greetings and congratulations for the honor that has been bestowed upon them by their fellow members in the Mississippi State Medical Association.

Dr. J. M. Acker, the new President, is one of the enthusiastic and active practitioners in the State. Dr. Acker is a splendid selection for the office of President and will make a worthy successor of the distinguished Dr. John C. Cully.

As President-Elect Dr. John W. D. Dicks of Natchez was elected by the organization. Dr. Dicks is one of the most charming and most delightful medical men in his State. He has obtained an enviable reputation as a surgeon of merit and skill.

The Journal also wishes to extend its congratulations to the new Vice-Presidents Dr. B. S. Guyton of Oxford; Dr. J. S. Hickman of Philadelphia; and Dr. Riley Burnett, of Biloxi To the other officers as well, some of whom have held office for some years, others who are new, we also proffer our congratulatory compliments.

AMEBIASIS IN THE SOUTHERN STATES.

Infections with *Endameba histolytica* may conservatively be said to be present in from 10 to 20 per cent of the population of the Southern states of this country. Faust[1] found that in the New Orleans clinic population about 13.7 per cent were infected, and that in Charity Hospital at New Orleans 27.2 per cent infection was present in patients in male medical wards, 13.1 per cent in female medical wards, 25.2 per cent in patients of the obstetrics service, 8.27 per cent in medical students, and 9.05 per cent in private, pay patients. Indeed, not a few workers are inclined to feel that such infections constitute as definite a medical problem as hookworm disease in the South.

Several observers emphasize the fact that actual dysentery with blood and mucus in the stools occurs in only a small number of the cases harboring this protozoan parasite. They argue for a more general recognition of the existence of other pathologic states than dysentery as produced by this parasite, and point out that there may be produced amebic dysentery, subacute and

chronic amebic enteritis, amebic abscess of the liver, amebic hepatitis and amebic carrier state. Craig[2] concludes that *"Endameba histolytica* is essentially a tissue parasite and that there can be no infection with this parasite without the production of pathologic lesions, however minute such lesions may be."

Craig[3] has described a definite symptom-complex as found in persons with chronic or carrier states of the disease, which states are recognized conclusively by the demonstration of the cyst stage of the parasite in the feces. The symptoms are connected with the gastro-intestinal and nervous systems and include chronic constipation with intervals of more or less severe diarrhea, capricious appetite, periods of anorexia, flatulence and distention of the abdomen, and dull aching sensations in the lower part of the abdomen. There are also often present neuralgic pains in the head and extremities, dullness and lack of interest in the daily work, and nervous irritability.

Identification of this parasite, particularly the encysted stage, requires a competent and experienced observer. Personal communications from laboratory workers engaged in routine examination of the feces —a procedure which many physicians are coming to regard as of equal importance with routine examination of the blood and urine—would make it appear that an unusual number of patients with acute amebic dysentery are presenting themselves for diagnosis and treatment in the spring months of 1932.

Conjecture as to the underlying cause for increasing incidence of such cases would assume that the present period of depression through which our people are passing his impelled such modifications of the usual diet of at least a portion of our Southern population as to lead to increased opportunities for infection and to decreased resistance on the part of the individuals subjected to infection with a consequent increase in the number of such cases. Certainly the problem of amebiasis is a very real and present one. The diagnosis and thorough treatment of such cases by physicians is important in preventing the further dissemination of the disease and assuring the health of the public in the South.

1. Faust, E. C.: The incidence and significance of infestation with Endamoeba histolytica in New Orleans and the American tropics, Am. J. Trop. Med., 11 :231, 1931.

2. Craig, C. F.: The amebiasis problem, J. A. M. A., 98; 1615, 1932.

3. Craig, C. F.: Symptomatology, diagnosis, and treatment of carriers of Endameba histolytica, J. A. M. A., 90: 1345, 1928.

HOSPITAL STAFF TRANSACTIONS

SURGICAL STAFF OF CHARITY HOSPITAL.

The Surgical Staff of Charity Hospital held its regular monthly meeting on May 18, at 8:00 p. m., in the Nurses' Auditorium. There were forty members present. Dr. I. M. Gage, Chairman, presided. The minutes of the previous meeting were read and approved. There was nothing to be considered under the heads of reports of committees, new, old, or unfinished business, so the meeting passed to the scientific session.

Dr. Arthur King reported a very interesting case of a colored female, aged 19 years, para three, who was admitted at term showing hemiplegia. Syphilis and arteriosclerosis were ruled out. She had had no hypertention or albuminuria and no prodromata of eclampsia until this sudden onset. She passed into coma and a living child was delivered by caesarean section. The mother died and autopsy showed the cerebral hemorrhage and pathological changes in kidneys and liver identical with eclampsia. This case is described as "eclampsia without convulsions" on the authority of Williams, and takes its place with forty-three others described in the literature, eight of which terminated in cerebral apoplexy. The case will be reported in detail elsewhere. Pathology of eclampsia was discussed by Dr. Von Haam. Dr. C. Jeff Miller discussed the case from the standpoint of pathology and treatment and sounded a warning against early operation in eclampsia in general; also suggested therapeutic bleeding by venesection.

Dr. John H. Connell from the Department of Pathology then gave a report of the work done during the past year on tissue removed at operation and submitted for examination and diagnosis. The summary follows:

Gynecologic: uterine fibrosis 318; uterine fibroids 522; placenta 1; uterine carcinoma 7; uterine scrapings 396; tubes 896; ovary 847; cervix 315; vagina 9; labia 21; total 3,342. Oral: mandible 5; maxilla 6; total 10. Neuro: brain tumors 3; nerve tumors 1; total 4. Neck: thyroid 72; post bronchial struma 1; salivary gland 5; total 78. Orthopedic: amputations 66; bone scrapings 10; total 76. Biopsy diagnosis: skin 82; lymph glands 94; lip 4; sacrum 11; subcutaneous 28; total 219. Abdominal: appendix 3,764; gallbladder 172; stomach 19; pancreas 3; spleen 3; intestines 17; rectum 56; mesenteric cysts 1; omentum 8; liver 1; total 4,046. Breast: inflammation 9; tumors 127; total 136. Genito-urinary: kidney 33; bladder 3; prostate 74; testes 17; penis 32; total 159. Ear-nose throat: antrum 2; nose 2; eye 4; epiglottis 1; larynx 3; vocal cords 1; lungs 1; esophagus 1; tonsils 2,405; total 2,420. Total number of neoplasms: 312. Cervix 25 per cent; breast 19 per cent; penis 7 per cent; skin 6 per cent; rectum 5 per cent; stomach 3.9 per cent.

This, of course, proved of much interest to the Staff, and indicated the extent to which the Department of Pathology is cooperating with the Surgical Staff. Dr. Connell then discussed classification of carcinoma of the breats saying "The old problem of classification of neoplasms being only of interest to the pathologist has become obsolete. Due to the advancement of the knowledge concerning neoplasms in general, their morphology and their biological activities, it is essential that the surgeon and clinician become better acquainted with it. The old classification of carinoma of the breast was based on an anatomical arrangement of the cells, such as: adeno, schirrous, simplex, medullary carcinoma, etc.; it must be supplanted by terms of use to the clinician. The pathologist should endeavor to give information as to the characteristics and activities of the neoplastic cells and grade them according to the degree of malignancy, thereby determining the further course of the tumor and prognosis of the patient. The advancing knowledge of radium sensitivity in direct proportion to the de-differentiation of the cells, makes such a classification extremely important especially in treating that grade of highly malignant tumor." The discussion was amplified by gross specimens and microscopic sections.

This being the last meeting of the spring session the Staff adjourned until October, when the first meeting will be devoted to the election of officers.

STAFF MEETING OF THE KING'S DAUGHTER'S HOSPITAL, GREENVILLE, MISSISSIPPI.

The regular monthly meeting of the staff of the King's Daughters' Hospital at Greenville, Mississippi, was held on May 4, 1932, in the dining room of the hospital, where a good dinner was enjoyed by those present.

It was Leflore County night, and the following visitors were present from Leflore County: Drs. Dickens, Kennedy and Baskervill, all of Greenwood.

The following members of the staff were present: Drs. John Lucas, B. Lewis, J. A. Beals, H. A. Gamble, John W. Shackleford, F. M. Acree, P. G. Gamble, O. H. Beck, C. P. Thompson, L. C. Davis, R. D. Dickens, R. E. Wilson, John Archer, A. G. Payne, J. C. Payne, J. B. Hirsch and George Eubanks.

After partaking of a delightful dinner, routine business matters of the hospital were taken up and disposed of. During this time attention was called to the fact that our attendance since the first of January has been well above 90 per cent, and at the present meeting all case histories have been properly written and filed. This is a record we are proud of, and it manifests a keen interest in the hospital and its workings.

A case report was given on "Syphilitic Osteitis of the Skull" by Dr. F. M. Acree, and a case report on "Syphilitic Gumma of the Dura" was given by Dr. O. H. Beck, after which these two case reports were opened for general discussion and were discussed at length by Drs. T. B. Lewis, J. A. Beals, H. A. Gamble, C. P. Thompson, A. G. Payne, and John Archer, and also by Drs. Baskervill and Dickens of Greenwood. The discussion was closed by Drs. Acree and Beck.

The officers of the Staff are:

President, Dr. John Archer.

Vice-President, Dr. J. B. Hirsch.

Secretary, Dr. R. E. Wilson.

Chairman of the Section on Medicine—Dr. T. B. Lewis.

Chairman of the Section of Surgery—Dr. Paul Gamble.

Chairman of the Section on Specialties—Dr. D. C. Montgomery.

Abstract—Syphilitis Osteitis of the Skull.—Dr. F. M. Acree.

Patient—Colored male, aged 35 years. Chief Complaint—Sore on head. Past History—Usual childhood diseases; pneumonia at the age of 30 years; smallpox at the age of 23 years; lost last phalanx of right index finger at the age of 25 years; operations none; sore on penis at the age of 17 years; gonorrhea five times, the last time last year. Family History—Father dead, cause unknown; mother living and well, one brother living and well; no brothers dead; four sisters living and well; two sisters dead, cause unknown; married; no children; no miscarriages. Present Illness—In 1922 had sore in nose, which continued until September, 1929, when there appeared a swelling in mid-line of forehead just

above nose. This continued to swell for three days when he saw a doctor, who opened and drained it. Dressings were applied for three months but the drainage continued. He was given three shots of 606 during this time. Since then it has continued to drain. Physical Examination—Negro male; well developed and nourished; walked in. Head: Swelling on forehead; one open sinus in mid-line just over nose and one opening four c m. above; discharge foul smelling; bridge of nose sunken; septum eroded away; foul odor to discharge somewhat similar to discharge from sinus above. Eyes—Negative; Throat—Negative and congested; Lungs—No dullness on percussion; no rales heard. Heart—Not enlarged; no murmurs; no irregularities.

Abdomen—No masses nor tenderness; Extremities—Negative; Genitals—Negative; Skin—Normal. Laboratory Analysis: Blood count—Hemoglobin 55 per cent; red cells 3,070,000; white cells, 6,900; small lymphocytes, 7 per cent; eosinophils 5 per cent. Blood Wassermann—3-plus. Urine—Cloudy, foul odor; yellow color; alkaline reaction; specific gravity—1.012; albumin—negative; blood cells—negative, sugar—negative; six to eight pus cells to high power field; indican heavy; occasional waxy cast; many epithelial cells. Treatment—Intensive routine antisyphilitic, including neosalvarsan, bismuth, mercury and the iodides. Later, if necessary, the operative removal of bony sequestrae. Prognosis—Guarded.

Abstract: Case Report, Dr. O. H. Beck.

I am reporting this case tonight because of two reasons. First, I made a blunder in my diagnosis thinking I was dealing with a lipoma, the reason being that I did not take a careful history. Second, the common error that we all make in the haste in which we make diagnosis. I fulfilled the old dictum of operating and then making a diagnosis.

Patient—Negro male, 29 years of age came to the clinic March 28, 1932. He complained of a cystic tumor which was situated at the junction of the right parietal and frontal bones which gave him the characteristic look of a "Happy Hooligan." The tumor mass was noticed about three months ago. Since then it had grown rather rapidly and had attained the size of an orange. The patient has suffered with headaches, chronic in type, which were relieved about the time of the appearance of the tumor. General malaise and nervousness had been a persistent symptom for the past six months. His headaches at first were nocturnal in type; later persisted throughout the day. He had lost some weight, had a good appetite, slept rather poorly, complaining of dreams that were of the grandiose type, has had loss of memory and power of concentration more marked the last few weeks. Past History—Usual diseases of childhood, syphilitic ulcer in the year 1925; malaria, 1928; denies infection of gonorrhea. Physical Examination—Negro male, 29 years of age, whose appearance was rather dull and his activities listless. His eyes reacted to light and accommodation, a sign that I thought would sure be positive. The nose showed a chronic deviated septum. The posterior pharyngeal lymphoid tissue was greatly thickened, the tonsils were infected and hypertrophied. There was a tumor about the size of an orange that arose just outside the hair border at the junction of the right frontal and parietal bones. The tumor mass was of a consistency of a cyst and showed no signs of being adherent below. The skin moved freely over it. There seemed to be a thickening and swelling of the skin around the base of the tumor. There was no pulsation of the tumor. The expansion of both chests was full and equal. No rales were present. The blood pressure was 115/60; temperature 98.4° F.; pulse 84; differential count, polymorphonuclears, 68; large mononuclears, 10; small lymphocytes, 22. The apex beat of heart was in the fifth interspace. There were no arrhythmias or murmurs present. The abdomen was of normal contour, the liver and the spleen were not palpable. The extremities were negative except for hyperactive knee jerks. There was a generalized glandular adenopathy, inguinal, cervical and epitrochlear. The Wassermann was three-plus in both antigens. Roentgenogram revealed an exostosis of the inner table of the cranium with an opening about the size of a half dollars at the junction of the right parietal bones. The bone was thought to be definitely syphilitic. At the time this patient entered my office I was busy, and on superficial inspection without much more history than the usual questioning in cystic tumors of the skin I at once had the nurse to make preparations to remove the tumor. After the skin was incised and the tumor dissected to its base I knew that I was dealing with either a syphilitic or a malignant tumor that arose from the dura and felt sure that the tumor had eaten its way through the bone by pressure. The tumor was dissected from off the dura and a section was sent to the pathological laboratory, where syphilitic gumma was beautifully demonstrated. I am quite certain that if I had taken a careful history and made a careful physical examination that, I would not had so much trouble in removing the tumor, for I am quite sure that anti-syphilitic treatment would have removed it for me. I am interested in knowing how to cure these individuals that have associated with their cerebrospinal syphilis, syphilitic ostitis of the skull. The discharging sinuses are very annoying and unpleasant to deal with.

F. M. Acree, Secretary.

MISSISSIPPI STATE BAPTIST HOSPITAL, JACKSON, MISSISSIPPI

The Staff of the Mississippi State Baptist Hospital met in regular monthly session in the dining room of the hospital on the evening of May 3, with 25 members enjoying the wonderful chicken dinner served to them.

Immediately after the dinner Dr. Garrison called the meeting to order and read the minutes of the previous meeting which were approved as read. Mr. Alliston made, as Superintendent, some very important remarks about the recent inspection by the American College of Surgeons representative, who found all the charts up and in order and as well be found a very complete record of the meetings of the staff. He also reported a very interesting bit of data in that all the rooms of the hospital were occupied, though the porches and wards were empty.

Case report by Dr. Robin Harris:

White female of undertermined age, who had previously had all of her teeth removed as well as her tonsils and who was having very severe pain and swelling in the right ankle joint. On examination she was found to have an antrum which was discharging cheesy pus and which was very cloudy by roentgen ray examination. A diagnosis of empyema of the antrum was made and the antrum was punctured and washed out well a number of times and on the tenth day after the institution of the treatment she was discharged as well and free from all symptoms and signs of her previous trouble with her ankle.

Case Report by Dr. Diamond—A colored female, aged 23 years, who came to the hospital complaining of pain in the lower part of her abdomen and pelvis and who had not menstruated for eight months. It was discovered in eliciting a history that she had had very painful menses with some increase in the vaginal discharge before the menses started, then that it ceased. She had been suffering with mausea and vomiting and constipation throughout the course of the past eight months. She had some bleeding and pain from the region of the rectum. Coitus had been most painful, expecially during the past month.

Physical Examination revealed a normal looking colored female who seemed to have a very large abdomen. She showed the usual signs of pregnancy but otherwise was negative on physical examination, except by vaginal examination. In doing a bimanual examination there was elicited a great deal of pain and there was encounted a mass in the right side of the pelvis which would not allow the finger to pass by same and which did not seem to be attached to the gravid uterus. A roentgengram was made and a large calcified mass was seen on the right side of the pelvis which seemed not to be attached to the ileum at any portion. The child in utero was seen and showed no attachment to the mass. Diagnosis: Osteoma of the right ovary. Operative Procedure: A laparotomy was done and the child delivered by caesarean section was normal in every way. The uterus was closed and then this mass was found in the region of the right ovary and attached to same by pedicle. This mass was stony hard in texture and was removed, being about the size of a large grape-fruit. The mother and child made an uneventful recovery. The specimen was passed and observed. No microscopic section report was available at this time.

This case was discussed by Dr. Shands who reported a similar case encountered at operation for eclampsia in which a caesarian section was done. Dr. Frank Hagaman also discussed this case mentioning some similar cases but not osteoma of the ovary.

Dr. F. E. Rhefeldt discussed a very interesting case of death from generalized arteriosclerosis and hypertension, with multiple spontaneous hemorrhages over a long period of time.

Dr. Garrison called the staff's attention to the fact that this staff is not a medical society and that the matters of the hospital should be brought up as well as the cases of interest and be freely discussed by all.

Mr. Palmerlee, in charge of laboratories, urged that the members of the staff seek to obtain more autopsies because of their educational value, as well as offering a more complete record of the deceased cases.

The meeting was adjourned until 6:30 p. m., June 7.

Lawrence W. Long, Secretary.

VICKSBURG SANITARIUM AND CRAWFORD STREET HOSPITAL, VICKSBURG, MISS.

The regular monthly meeting of the staff of the Vicksburg Sanitarium and Crawford Street Hospital was held on May 16, with ten members and two visitors present. Dr. G. M. Street, President, presided. After a business meeting and reports from the records department and analysis of the work of the hospital, the following special case reports were presented:

General Carcinomatosis of the Peritoneum—Dr. G. M. Street.

Fracture of the Shaft of the Humerous with Non-Union; Intramedullary Autogenous Bone Transplant.—Dr. A. Street.

Congenital Syphilis (Two Cases).—Dr. G. C. Jarratt.

Abstract: Patient.—Colored female, aged 7 weeks, first seen April 4, 1932. Chief Complaint, crying; cannot use arms or legs; sore mouth; cold; pain on moving. Present Illness.—Mother stated infant had seemed to progress fairly well up to ten days previously, except had had a "cold" since birth. Ten days previous

mother noted child cried as if in pain when being dressed; three days later noted did not raise arms and use them as before, also began to hold knees flexed on abdomen and legs flexed on thighs. Had not noted any glandular enlargement. Sores appeared about mouth and lips about ten days previous and had cried night and day since that time. No fever before or since onset of symptoms. Mother had had Wassermann test during pregnancy; reported negative. Past History.—No illnesses except present. Birth: Normal cephalic delivery without instruments; no cyanosis or convulsions; nursed well. Feeding: Nursed from breast for three weeks and then put on condensed milk, 1 teaspoonful to 4-oz. water and given when child cried, with no regularity. Family History.—Mother living and apparently well; one miscarriage at 4 months between first and second normal births. Father living and in good health. Five other children living and well; none dead. No tuberculosis contact. Physical Examination.—Weight 9 lbs; fairly well developed but poorly nourished; arms lying at sides; legs flexed upon thighs and thighs flexed upon abdomen; cries when disturbed. Pupils equal but fixed; nasal cavities filled with bloody exudate, fissures around orifices, septum ulcerated; fissures around mouth, bleed easily; ulcers on soft and hard palates, bleed easily. Liver, fingers breadth below costal margin; small umbilical hernia. Ulcerations between labia. Fissures about anus. Inguinal and femoral glands enlarged. Grating and crepitation at albows, knees, and ankles, also at shoulders; apparently very painful as cried out upon manipulation. Marked swelling of epiphyseal areas of lower and upper tibial, fibular, ulnar and radial regions. Moved fingers but when arms were raised, cried with pain. Wassermann, Kahn, and Kline and Young tests on mother and infant positive (4-plus). Roentgen ray examination of long bones showed extensive epiphysitis and osteo-chrondritis of femur, tibia, fibula, ulna, radius and humerus of both sides. Course and Treatment.—April 4: Gave 0.05 gm. sulpharsphenamine intramuscularly; yellow oxide of mercury ointment in nose daily; inunctions of mercurial ointment daily; formula of one-half oz. condensed milk in 3½ oz. water to be given at 6, 9, 12, 3, 6, 10, and 2 o'clock; cod liver oil twice a day; syrup of ferrous iodide three times daily.

April 6—Gave 0.05 gm. sulpharsphenamine intramuscularly. April 10: 0.05 gm. sulpharsphenamine intramuscularly. Mother reported child sleeping much better and using arms and legs and does not cry with pain upon moving; snuffles improved. Can extend legs with no pain but swelling and crepitation of joints still present. Mouth and anus healing; ulcers of palate healing.

April 14:—Gave 0.05 gm. sulpharsphenamine.

April 21:—Weighed 9½ pounds. 0.05 grams sulpharsphenamine, strapped umbilical hernia. Moves arms and legs with no pain but still evidence of epiphyseal enlargement. Fissures healing; snuffles less.

April 28:—0.05 gram sulpharsphenamine. Advised use of mercury by inunction twice weekly only. Continued syrup of ferrous iodide. Put on formula of cow's milk, 10 oz., water 8½ oz., Karo two teaspoons, to be given 3½ oz. at 6, 9, 12, 3, 6, 10, and 2 o'clock.

May 5:—0.05 gram sulpharsphernamine. Roentgengram of bones revealed healing. Taking formula; sleeps well; having one to two normal stools daily. Fissures healed; snuffles cleared; can use arms as normal infant; epiphyseal enlargement still present at ankles, wrists, and knees, and beginning sabre shin formation.

May 12: 0.05 gram sulpharsphenamine. Restrapped hernia. No bulging of hernia except when strap removed.

Future Course of Treatment—Infant has had eight doses of 0.05 gram sulpharsphenamine. Will give mercury succinimid, gr. 1/70, intramuscularly for ten doses; then repeat eight doses of 0.05 gm. sulpharsphenamine and again ten doses of mercury and then ten doses of bismuth, the dosage according to age. Will then repeat Wassermann and if negative will treat for one year and repeat Wassermann on blood and do spinal fluid Wassermann at six months intervals, the treatment to depend on result of tests.

Patient.—Colored female, aged 7 weeks, first seen April 23, 1932. Chief Complaint—Cold: breaking out on body; fretful. Present Illness. —Mother stated child had had a cold with running nose since birth. One week ago noticed eruption on buttocks and later on abdomen. During previous week infant had rested very little either at night or during days. Past History—No illness except present one. — Birth History. — Normal cephalic delivery without instruments at nine months; no cyanosis or convulsions; cried huskily and nursed well from start. Family History.— Mother treated in this clinic four years ago for syphilis at which time Wassermann test was four-plus. Mother living and well. No miscarriages. One other child 13 years old, living and well. No children dead; no tuberculosis contact. Physical examination.—Weight 7¼ pounds; small, but well developed and fairly well nourished infant, fretful and crying. Mucoid discharge from nose, excoriations in nares and also at orifices; no ulceration of septum. There was opacity of lens of right eye and also small areas, size of pinhead to medial side of pupil in iris. Pupils distorted and fixed in left eye and did not react to light. Fissures on lip. Lymph glands of

neck small and shotty, freely movable. Small umbilical hernia. Excoriatations about labia. Anus showed fissures. Generalized enlargement of lymph nodes, small, shotty, freely movable under the skin. Skin shows maculo-papular and pustular eruption over buttocks, back, abdomen and thighs. Wassermann, Kahn, and Kline and Young tests positive (4-plus) on infant; negative on mother. Roentgen ray examination of long bones shows early epiphysitis and osteitis.

Course and Treatment.—April 23:—Instructed to instill 0.05 per cent atropin sulphate solution in each eye daily; instill 2 per cent yellow oxide of mercury ointment in nares daily; inunctions of mercurial ointment daily; syrup of ferrous iodide, 10 minims three times a day. Breast feedings at 6, 9, 12, 3, 6, 10, and 2 o'clock.

April 23.—0.05 gram sulpharsphenamine intramuscularly. Pupils dilated; left very irregular.

April 28.—0.05 gram sulpharsphenamine. Opaque areas in iris gone and opacity of lens about one-half original size. Snuffles less and rash disappearing.

May 1.—0.05 gram sulpharsphenamine; instructed to use inunctions twice weekly. Rash gone and at site of same there is a yellow brown pigmentation. Snuffles less and fissures healed. Sleeps well and nurses well two or three normal stools daily. Gave mother 0.03 gram neosalvarsan for provocative test.

May 5.—0.05 gram sulpharsphenamine. May 8.—0.05 gram sulpharsphenamine. Wassermann on mother negative; Kahn and Kline and Young tests positive (2-plus).

There are a few fine yellow granules in left eye, apparently on lens but not in iris. Rash, fissures and snuffles gone.

May 14.—0.05 gram sulpharsphenamine. No snuffles, rash or fissures. No epiphyseal enlargement. There are no granules in iris or lens but pupils dilated and very irregular. Stopped atropin in eye and yellow oxide of mercury in nose. Wassermann on mother again taken and reported, Wassermann, (4-plus); Kahn (4-plus); Kline Young (4-plus).

Future Treatment.—Will be similar to Case 1.

The following radiographic studies were presented and discussed:

Fracture of the humerus with delayed union; fracture of the femur with delayed union; osteoarthritis of the knee; gunshot fractures of both arms; tumor of the skull, benign; syhlilis of long bones; thorax for diagnosis; maxillary-sphenoid-ethomid sinusitis; stomach; end result of partial gastrectomy for carcinoma; fetus, breech presentation.

Reports of the recent meeting of the American Medical Association at New Orleans were presented by Drs. L. J. Clark and W. E. Johnston.

The report of the recent meeting of the American Society of Clinical Pathologists at New Orleans was presented by Dr. L. S. Lippincott.

The meeting closed with a lunch.

The next meeting of the staff will be held Friday, June 10.

Leon S. Lippincott, Secretary.

HOTEL DIEU STAFF MEETING.

The monthly meeting of the Hotel Dieu Staff was held on April 18, 1932 at 8 P. M.

Dr. Homer Dupuy presented a case of cerebral abscess cured. He stated the operative mortality is still 75 per cent. The patient came to him with a mastoid abscess on the right side, and high temperature. Mastoidectomy was performed. Intense right hemicrania continued. A week later craniotomy was done, revealing an extra-dural abscess with pus between the brain and the temporal bone. The dura was exposed and the wound left open. This operation gave immediate relief as to pain; however, there was still evidence of pus in the wound. Three weeks later, the head being tilted to the right, an enormous amount of pus was found in the brain itself—the temporal-sphenoidal lobe. The fistula giving exit to the pus was enlarged and quantities of pus evacuated.

The cure was possible because of the encapsulation of the abscess. There had been no localizing symptoms, nor other usual brain symptoms. After finding the cavity, a rubber catheter No. 1 was left in for drainage. This tube has been removed, and the brain abscess cavity seems dry.

Drs. Jules Dupuy and Louis Levy were associated in this case; the latter did a blood transfusion which helped the patient through the stormy post-operative period.

Dr. Louis Levy presented a case of double cystic malignant ovary, moribund on admission one year ago. Laparotomy revealed a bleeding, ruptured, malignant right ovary. The field was cleared and the ovary removed. There was considerable hemorrhage; transfusion was done. Deep therapy was given on the right side. The sinus drained for many weeks. Then a left side mass was noted. A partial left oophorectomy was done. In the interval the patient was given colloidal gold and is now getting it three times a day. She is in fairly good condition, having gained eighteen pounds within four months.

Dr. Maurice Couret stated he believes that some good always results from colloidal injections (gold, lead, copper, etc.) in all cases of malignancy, particularly sarcoma, but the good results are only passive. However, he stated that one colloid does not seem to do the work, and he is fearful of a recurrence in this case. He advised trying each metal in turn as fast as the full therapeutic reaction was obtained from the preceeding one.

Dr. Jerome E. Landry declared that in the majority of cases, after the use of colloidal gold, patients regain their health for a while, but they all die within a short time.

Dr. Levy, in closing, said that he does not expect a cure in this case, but is doing all that he can to help.

Dr. Theodore J. Dimitry presented an eye case of retinitis pigmentosa with an incidental hemorrhagic iridocylitis. There was a definite mass in the vitreous that had all the possibilities of malignancy known as neuro-epitheliomata or glioma of the retina; this left eye was to be enucleated the following day. The right eye was also diseased with retinitis pigmentosa. There was a definite relationship between this condition and the fact that the child was deaf and dumb. He is an inmate of Chinchuba Institute.

Dr. Dimitry also demonstrated the electric eye magnet; he explained that it is, of course, necessary to make an incision when using this magnet. The new instrument must be closer to the foreign body than the old-fashioned Haab magnet, but its strength when near is much greater. The purpose of the demonstration is to make known that Hotel Dieu is now the possessor of such an instrument and it is at the disposal of the medical profession.

Dr. J. T. Nix exhibited many interesting slides to demonstrate correction of congenital deformities of lip and palate. These operatives are performed as soon after birth as possible.

Dr. Ruth Aleman stated that babies with such deformities are poor risks in general, for they are prone to infection. If the infant is breast-fed, the risk is much better than otherwise. Babies suffering from malnutrition should be brought up to par before operating. The cuffs on the arms, as shown on the screen, are very necessary to keep the baby's hands away from its mouth.

Dr. J. B. Larose acknowledged himself to be convinced by the evening's talk that the earlier such operations are undertaken, the better it is for the patient.

Dr. Val Fuchs described the technic of Dr. Mackenty who, in order to keep the tongue from reaching the suture line, runs a through and through lead band, coming out on each side of the suture, and over that places a metal disc which is perforated for drainage. The lead band is tied across the disc, so that the child, when placing its tongue to the roof of its mouth, will place it over the disc. Dr. Mackenty has no trouble with sutures sloughing out.

Dr. A. L. Levin presented a number of lantern slides, demonstrating the effect of liver on peptic activity; he made the following remarks:—

"Liver therapy was known to the ancients over 2000 years ago. It was recommended in hydrophobia. Hippocrates advocated it in night blindness. In a compilation in the seventh century, the value of liver is highly praised. Again in the seventeenth century, the use of liver is urged in various diseases. Whipple in 1925 demonstrated its value in artificially produced anemia. Minot and Murphy deserve the badge of honor for switching pernicious anemia from the incurable class to the rank of diseases amenable to treatment, with the use of liver (1926.) The literature of medicine points to fourteen indications for the use of liver such as hypertension, malnutrition, hemorrhage, anemia, metabolism, liver function, etc. My studies for the past five years convince me that liver definitely influences peptic activity. I am able to demonstrate that cases of achylia gastrica studied with histamine are favorably influenced by liver therapy. In from several weeks to several months the acidity from zero returns to normal. How liver influences this function is a matter for further study. I believe that liver stimulates the product of histamine in the body and the stimulation of histamine influences the peptic activity. It is possible that liver itself contains a substance similar in its function to histamine. In advocating the use of liver in achylia gastrica, I also urge the removal of foci of infection. If a chronic gall bladder exists and is surgical in character, the surgeon should take charge of it and liver used if HCl is absent.

"The final chapter on achylia gastrica has not yet been written in spite of the excellent studies made by Fabre, Einhorn and others. Their pathologic specimens showing atrophy of peptic glands are not a proof that all cases of achylia must have atrophy as an underlying background. We see a large number of cases where the HCl and the enzymes are absent and still we can stimulate the peptic activity and bring the acid and enzymes back showing thereby that the glands have not been atrophied. My plea tonight is that we should not depend on histamine alone as a final indicator in achylia. Liver is a far better agent if used for a period of time."

Dr. D. S. Silverman:—"I doubt that any therapy will restore the secretion of the stomach after it has been absent following the administration of histamine. It is accepted by world authority that the differentiation between functional and organic achylia is based upon the action of histamine. (Achylia gastrica is now a term meaning not the absence of acid from the stomach, but a total absence of all secretions.)

"Ralph Major discovered that histamine is found not only in the liver and other organs of the abdomen, as the kidney and pancreas, but also in the brain and other tissues. Therefore, with the administration of these different substances, we are employing histamine. I have made use of pancreas for its trypsin instead of using pepsin; however, as Dr. Carlson reminded me, the administra-

tion of any protein might do as much toward increasing tryptic activity."

The Executive Session followed, after which the meeting adjourned.

Following the meeting a Clinico-Pathological conference was held, conducted by Dr. Maurice Couret, and comprising the following cases:

(1) Papillo-cyst-adenoma of ovary-benign, Dr. Walet;

(2) Tumor of right iliac fossa-fibromyoma, Dr. Menendez;

(3) Tumor from right side of neck, perithelioma of carotid gland, metastasis in lymph nodes, Dr. Danna.

TRANSACTIONS OF ORLEANS PARISH MEDICAL SOCIETY

TRANSACTIONS OF ORLEANS PARISH MEDICAL SOCIETY CALENDAR.

June 2—Clinico-Pathological Conference, Touro Infirmary, 11 A. M.

June 3—Pathological Conference, Hotel Dieu, 11 A. M. to 12 Noon.

June 6—Eye, Ear, Nose and Throat Hospital Staff, 8 P. M.

June 8—Touro Infirmary Staff, 8 P. M.

June 9—Clinico-Pathological Conference, Touro Infirmary, 11 A. M.

June 9—French Hospital Staff, 8 P. M.

June 10—Pathological Conference, Hotel Dieu, 11 A. M. to 12 Noon.

June 13—ORLEANS PARISH MEDICAL SOCIETY, 8 P. M.

June 16—Clinico-Pathological Conference, Touro Infirmary, 11 A. M.

June 16—New Orleans Hospital Council, Baptist Hospital, 8 P. M.

June 17—Pathological Conference, Hotel Dieu, 11 A. M. to 12 Noon.

June 17—I. C. R. R. Hospital, 12 Noon.

June 17—Mercy Hospital Staff, 8 P. M.

June 20—Hotel Dieu Staff, 8 P. M.

June 21—Charity Hospital Medical Section.

June 23—Clinico-Pathological Conference, Touro Infirmary, 11 A. M.

June 24—Pathological Conference, Hotel Dieu, 11 A. M. to 12 Noon.

June 27—ORLEANS PARISH MEDICAL SOCIETY, 8 P. M.

June 28—Baptist Hospital Staff, 8 P. M.

June 30—Clinico-Pathological Conference, Touro Infirmary, 11 A. M.

During the month of May besides the regular meeting of the Board of Directors the Society held one regular scientific meeting on May 23, at which the following program was presented:

Allergic Reaction by "Remote Control."
By.....Dr. Narcisse F. Thiberge.
Discussed by Dr. Allan Eustis

Oral Conditions Which a Physician Should Note in Diagnosing Disease.
By.....Dr. Fred J. Wolfe.

Action of Avertin on the Damaged Kidney.
By.....Dr. Clyde Brooks.
Discussed by Dr. I. M. Gage.

The Control of Troublesome Cough in Pulmonary Tuberculosis by the Use of Combined Bacterial Antigens with Extract Anterior Pituitary. A Preliminary Report.
By.....Dr. E. A. Bertucci.
Discussed by Dr. Chaille Jamison.

The meeting scheduled for May 9 was dispensed with because of the meeting of the American Medical Association.

The American Medical Association met here from May 9 to May 13 and was very much of a success. Sessions were held in all available auditoriums in the heart of the city, and all were very well attended. The entertainment features were in keeping with the dignity of the Association and have been commented on very favorably.

The Secretary's office was busy up to and following the convention making preparations and clearing up matters.

The first radio health talk sponsored by the Society was given over W. S. M. B. on Thursday, May 26. These talks will be given every Thursday over this station. Volunteers to read talks are requested to send in their names to the Secretary.

The following doctors were elected to membership during the past month:

ACTIVE MEMBERS—Drs. John J. Archinard, Hugh T. Beacham, Charles A. Born, H. B. deB. Seebold and Maurice Sullivan.

INTERNE MEMBERS—Drs. John A. Alvarez, Leo G. Davis and J. Edwin Granade.

ASSOCIATE MEMBER—Dr. Chas. W. Rossner.

We regret to report the death of one of our Active Members, Dr. Z. T. Young.

TREASURER'S REPORT.

ACTUAL BOOK BALANCE: 3/31/32	$3,688.76
Receipts during March	1,665.36
	$5,354.12
Expenditures	$3,947.72
ACTUAL BOOK BALANCE: 4/29/32	$1,406.40

LIBRARIAN'S REPORT.

The Library has added 83 books to its collection during April. Of these new accessions 56 were received by binding, 11 by gift, 4 by purchase and 12 from the New Orleans Medical and Surgical Journal. A notation of new titles of recent date is given below.

The daily record of Library procedures kept by each member of the Staff was continued through April 15, ending a five weeks' period. Such a record will be kept again at another season of the year to show the varied activities of the Library. Reference work April 1-15 is shown on the daily records. Since that time material has been collected on call on the following subjects:

Changing of intestinal flora by diet.

Determination of official connections, for program use, of men appearing on Sectional A. M. A. programs.

Prevention of blindness.
Diverticulitis with abdominal anuerism.
Weil's disease.
Experimental fractures.
Food poisoning.
Physiology of lymph.
Cardiospasm in infants and children.
Strabismus.
Cancer inheritance in mice (work by M. Van Slyke).
Esophageal stenosis.
Maternal and fetal deaths.
Myelomalacia.
Thrombosis of the anterior spinal artery.
Massive collapse of lung.
Potter's method of staining neurological fibrilla.
Cause of failure in autogenous vaccine therapy.
Chemistry of mercurochrome.
Porthyrin.
Blastomycosis cutis.
Work of Pratt on pneumonia.
Ganglio-neuroma.
Sedimentation test by Reyner.
Staining spirochaetes, method by Warthin.
Pilocartine.
Blood serum.
Thorium.
Gum acacia as a physiological useful colloid.
Bromo-seltzer.

The American Library Association registering over 1300 met in New Orleans, April 25-30. Miss Marshall made arrangements for 3 Library school dinners and 2 group breakfasts, helped with 2 exhibits, took two periods at the Information Desk and had charge of the free trip through Frenchtown arranged by the Entertainment Committee, engaging guides who took over 450 librarians through the Vieux Carre. A schedule was arranged by which each member of the staff attended at least one morning or afternoon sessions in addition to the regular ones.

NEW BOOKS.

American Neurological Association—Transactions. 1929.

American Laryngological, Rhinological and Otological Association—Transactions. 1931.

Rockefeller Foundation—Methods and Problems of Education v. 20. 1932.

Paget—Confessio Medico. 1931.

Cannon—Exercises on Anniversary. 1932.

Cushing—Intracranial Tumors. 1932.

Power—Foundations of Medical History. 1931.

Thorek—Surgical Errors and Safeguards. 1932.

Ball—Diseases of the Kidney. 1932.

Montague—Psyillium Seed. 1932.

Nicolle—Naissance, vie et mort des maladies infectieuses. 1930.

Rosenfeld—Gynecology and Urology for Nurses. 1931.

Wechsler—Textbook of Clinical Neurology. 1931.

Stedman—Nurses' Medical Lexicon. 1931.

Williams—Insanity Plea. 1931.

H. Theodore Simon, M. D., Secretary.

LOUISIANA STATE MEDICAL SOCIETY NEWS

H. Theodore Simon, M. D., Associate Editor

REPORT OF HOUSE OF DELEGATES TO THE GENERAL ASSEMBLY.

Gentlemen:

The House of Delegates of the Louisiana State Medical Society was called together at nine o'clock Monday morning, May 9, 1932, and again on Tuesday morning, May 10, 1932.

Immediately after the roll call Dr. C. A. Weiss of Baton Rouge read the Memorial Services for Deceased Members. As a tribute to the memory of the deceased the members rose and stood in silence for one minute.

The Fraternal Delegate from the Mississippi State Medical Association, Dr. E. H. Jones of Vicksburg, was introduced and made a few appropriate remarks.

The report of the President, Dr. S. C. Barrow, was read and received with a great deal of enthusiasm.

The report of the Secretary-Treasurer, Dr. P. T. Talbot, was read and adopted.

The report of the Chairman of the Council, Dr. H. E. Bernadas was read and accepted.

The Councilors of the Eight Congressional Districts reported the activities in their respective districts.

The various standing and special committees submitted their reports covering their activities during the past year, which were adopted by the House of Delegates. Of particular interest was the report of the Committee on Cancer. This report was followed by an address by Dr. C. C. Little, representing the American Society for the Control of Cancer, who briefly outlined the work of the Society for the Control of Cancer to the meeting. The Committee on Budget and Finance recommended that future investments be made in United States Government bonds.

The valuable and extensive report of the Louisiana State Board of Medical Examiners was read and received. The names of Dr. C. Grenes Cole and Dr. Leon J. Menville were elected to be submitted to the Governor in lieu of the expiration of term of office of Dr. Leon J. Menville.

The House of Delegates received a valuable report from our Fraternal Delegate to the Mississippi State Medical Association, Dr. Allan Eustis.

The House of Delegates voted to extend an invitation to the Interstate Post Graduate Medical Assembly of North America to hold their 1933 meeting in New Orleans.

In regard to a communication received from Dr. W. C. Woodward, Director of the Bureau of Legal Medicine and Legislation of the American Medical Association, the House adopted a resolution that the matter of criminal institutes in Louisiana be referred to the Legislative Committee with power to canvass the situation and take such steps in the future as will bring the matter to the public in such a form that ultimately we will be the beneficiary of an institute for criminals.

A resolution was adopted condemning the practice of certain health units in the State entering into competition with the doctors, and requesting the State Board of Health to take necessary steps to stop it effectively.

The House also adopted a motion that the Louisiana State Medical Society go on record as memoralizing the State Legislature to repeal the state narcotic law.

A resolution was adopted condemning the use and abuse of our State Hospitals by the non-indigent, which is becoming more serious each year and is seriously affecting the doctors of the whole State, and that Committees be appointed from Shreveport and New Orleans to investigate the problem and report their findings with recommendations to the Governor of the state, the respective boards and superintendents of the hospitals.

A resolution was adopted that whereas about half the physicians of our state have no contact with our Society, and that as our Journal contains much which might induce them to join the State Society, that the matter of sending the Journal to all non-members in the state, if the finances can be arranged, be referred to the Journal Committee for action.

A resolution was adopted that whereas the young physician just entering the practice of medicine has had, with few exception, no business training, and that we all recognize to carry on properly due consideration must be given to the business side of our work, and the Bureau of Medical Economics of the American Medical Association has taken notice of this and is recommending that medical colleges arrange for lectures on Medical Economics to their students, that the State Society endorse this work in principle and recommend to the medical schools of Louisiana that they adopt same in practice.

A resolution was adopted providing that as the profession generally should be appraised of the activities for the coming year of the incoming President, that the President of the Society be publicly installed at the annual meeting at which time he shall set forth, as near as he can, his program for the coming year.

A resolution was adopted providing that the Chairman appoint a Committee of three to investigate carefully from every standpoint the feasibility of the plan of a full-time, trained executive whose duty it will be to devote his whole time in cooperation with the component Parish and

District Societies in planning and putting into effect programs for the public, as well as the profession, which will rebound to the interest of the medical profession and the public in general, and report with recommendations at our next annual meeting.

A motion was adopted that the matter of the controversy between the East Baton Rouge Parish Medical Society and the council of the Louisiana State Medical Society with reference to the transfer of membership be referred to the incoming Executive Committee.

The Committee on Resolutions begs to report that the Louisiana State Medical Society expresses its high appreciation and thanks to the following, to-wit:

To Dr. John A. Lanford, President, and the members of the Orleans Parish Medical Society, hosts in this auspicious meeting.

To Dr. Shirley C. Lyons, Chairman of the Committee on Arrangements, and to the Chairmen and Sub-Committees for their indefatigable labors in making this Convention a success.

To President Dinwiddie and Dean Bass of the Medical Department of Tulane University for the use of the offices and Auditorium of the Hutchinson Memorial, and for their sumptuous luncheon.

To Dr. Arthur Vidrine, Dean of the Louisiana State University Medical Center, and Superintendent of Charity Hospital, and his Staff, for their splendid luncheon.

To the Retiring President, Dr. S. C. Barrow, in appreciation of his able, tactful and brilliant administration.

To Dr. P. T. Talbot, Secretary-Treasurer of the State Society, for the fine manner in which he has conducted the affairs of his office, evidenced by the outstanding progress manifested in the affairs of the Society.

To Mrs. Mary Crossen Kagy, Assistant Secretary-Treasurer, and Miss Shirley Osborne of the Louisiana State Medical Society, for their devotion to duty and interest in the discharge of their duties.

To Dr. J. J. Ayo, Chairman of the House of Delegates, for the expeditious and impartial rulings that greatly facilitated the sessions of the House of Delegates, and to the New Orleans Press.

The following officers, being duly nominated, were elected:

President—Dr. Roy B. Harrison, New Orleans.

President-Elect—Dr. C. A. Weiss, Baton Rouge.

First Vice-President—Dr. J. T. Nix, New Orleans.

Second Vice-President—Dr. C. M. Horton, Franklin.

Third Vice-President—Dr. W. P. Butler, Shreveport.

Secretary-Treasurer—Dr. P. T. Talbot, New Orleans.

Councillors:

First District—Dr. H. E. Bernadas, New Orleans.

Second District—Dr. D. N. Silverman, New Orleans.

Fourth District—Dr. W. H. Browning, Shreveport.

Fifth District—Dr. J. P. Vaughan, Monroe.

Committees:

Committee on Scientific Work—Dr. P. T. Talbot, Chairman; Dr. A. E. Fossier; both of New Orleans; Dr. T. P. Lloyd, Shreveport.

Committee on Public Policy and Legislation—Dr. C. A. Weiss, Chairman, Baton Rouge; Dr. F. M. Johns, New Orleans; Dr. Glenn J. Smith, Jackson; Dr. Roy B. Harrison, President, New Orleans; Dr. P. T. Talbot, Secretary-Treasurer, New Orleans.

Committee on Medical Defense—Dr. E. L. Sanderson, Shreveport, for a term of three years.

Committee on Hospitals—Dr. Chas. Chassaignac, Chairman, New Orleans; Dr. J. L. Scales, Shreveport; Dr. O. P. Daly, Lafayette; Dr. C. P. Gray, Monroe; Dr. A. J. Comeaux, Youngsville.

Committee on Health and Public Instruction—Dr. W. H. Seemann, Chairman, New Orleans; Dr. F. R. Gomila, New Orleans; Dr. G. M. G. Stafford, Alexandria; Dr. J. Q. Graves, Monroe; Dr. J. K. Griffith, Slidell.

Committee on Journal—Dr. W. H. Seemann and Dr. Randolph Lyons, both of New Orleans, for terms of three years each.

Delegate to the American Medical Association—Dr. W. H. Seemann, New Orleans, 1933 and 1934.

Alternate to the American Medical Association—Dr. A. A. Herold, Shreveport, 1933 and 1934.

Dr. J. J. Ayo of Raceland was re-elected as Speaker of the House of Delegates.

Lake Charles was selected as the next place of meeting in 1933, the dates to be determined later by the Executive Committee.

Respectfully submitted,

P. T. Talbot, M. D.,
Secretary-Treasurer.

ECHOES OF THE AMERICAN MEDICAL ASSOCIATION.

The meeting of the American Medical Association in every way was a great success, despite the fact that the attendance, somewhat under 3,000, was not as large as it had been in the past few years. This was to be expected, however, in view of the present economic condition of the country, so that as a matter of fact the registration was greater than was anticipated.

Dr. Dean Lewis, Professor of Surgery of John Hopkins, was elected as President. Dr. Rudolph Matas was again honored by the organization, being elected First Vice-President. Dr. Clyde Brooks was selected as Chairman of the Section on

Pathology and Physiology. Several of the local men were elected as Vice-Chairmen of the Sections. Dr. I. I. Lemann was made Vice-Chairman of the Section on Medicine; Dr. W. H. Perkins was elected as Vice-Chairman of the Section on Public Policy and Hygiene; and Dr. J. H. Musser as Vice-Chairman of the Section on Therapeutics and Pharmacology.

Milwaukee was selected as next year's convention city.

Dr. H. W. E. Walther, of New Orleans, represented the Section on Urology in the House of Delegates of the American Medical Association at their recent meeting. As he was elected, in Philadelphia, for a term of two years, he will represent his Section again in Milwaukee next year.

A splendid tribute was paid to the memory of Dr. Marcus Feingold by the Section on Ophthalmology. Resolutions were adopted honoring Dr. Feingold, and at the termination of these ceremonies the Section as a body went to Metairie Cemetery to place a wreath on the grave of this distinguished ophthalmologist, for many years Professor of Ophthalmology in Tulane Medical School.

During the week of the American Medical Association the Louisiana State Coroners Association met. Dr. Willis Butler of Shreveport was elected President; Dr. L. L. Ricks of Independence, Secretary-Treasurer; and Dr. C. M. Horton of Franklin was elected Vice-president of the organization.

Dr. Cecil Lorio of Baton Rouge was elected President of the Louisiana State Pediatric Society, which was held during the week of the American Medical Association. Dr. E. R. Socola and Dr. Maud Loeber of New Orleans were elected Vice-president and Secretary-Treasurer respectively.

One of the interesting features of the meeting were the conferences of the special societies. The American Heart Association had a two day session preceding the meeting. The Association for the Study of Allergy also met on Monday and Tuesday, and the American Committee for the Control of Rheumatism had a splendid program. The American Society of Clinical Pathologists had a most enthusiastic convocations on May 6 and 7, while the Medical Veterans of the World War celebrated with their annual dinner on the night of May 10.

The social events of the American Medical Association were well attended, and the several committees that had to do with the President's Reception, the medical school banquets, and other social activities, deserve much credit for the splendid entertainments they provided for the members of the national organization.

To be congratulated are the ladies of the Woman's Auxiliary. Under the able leadership of Mrs. Joseph Hume they provided a series of entertainments and pleasureable events which reflected great credit on their hospitality and afforded a most cordial reception of the visitors. The entertainments were so varied and so diverse that no stranger in the City who partook of them all could have left without having learned much of New Orleans, old and contemporaneous, as well as having a delightful and agreeable time.

DEDICATION OF THE NEW LOUISIANA STATE UNIVERSITY MEDICAL CENTER.

On Tuesday, May 10, a most impressive ceremony took place when the New Medical School Building of the Louisiana State University Medical Center was formally dedicated. The dedicatory exercises were held on the lawn of the hospital between the Dibert Memorial and the new building. Here a large audience congregated to hear a series of splendid addresses and talks. Dr. Arthur Vidrine, Dean of the Medical School, gave the opening address. He explained why the new medical school should rapidly become one of the great schools of the country. A splendid building, a wealth of clinical material, and an excellent faculty would make this possible. Following Dr. Vidrine's talk Dr. James M. Smith, President of the University, gave a short address, and following this Mr. C. L. Weiss, the architect of the building, officially presented it to the Louisiana State University. A number of addresses was then given by distinguished medical educators, including Dr. Kenneth M. Lynch, Professor of Pathology at the University of South Carolina; Dr. Joseph Collins of New York; Dr. Stuart Graves, Dean of the University of Alabama School of Medicine; Dr. Alfred W. Adson, Associate Professor of Surgery at the Mayo Foundation. These addresses were followed by two on public health matters. Dr. Jacob C. Geiger, Director of Public Health in San Francisco, a graduate of Tulane; and Dr. Geo. W. McCoy, Director of the National Institute of Health, United States Public Health Service, spoke most stimulatingly. The last two speakers of the day were Governor-Elect O. K. Allen, and Senator Huey P. Long.

NEWS ITEMS.

Prof. O. W. Bethea, of the faculty of the Graduate School of Medicine of The Tulane University of Louisiana, attended a meeting of the Revision Committee, U. S. Pharmacopoeia at Philadelphia, Pa., April 30, 1932.

Dr. Bethea also attended the meeting of the American Therapeutic Society held at Baltimore, Md., May 16 and 17, 1932, and presented a paper on "Differential Diagnosis of Diseases of the Lungs." He was elected to the Council of the Society for a five year term.

On May 3, 1932, Prof. F. E. LeJeune, of the faculty of the Graduate School of Medicine of the Tulane University of Louisiana, held a clinic and addressed the meeting of the Dallas Academy of Ophthalmology and Otolaryngology on "Suspension Laryngoscopy and Cinematographic Study of the Larynx."

Asst. Surgeon Thomas B. McNeely, was relieved from duty at New Orleans, La., on or about May 25, 1932, and assigned to duty at the Marine Hospital, Ft. Stanton, N. Mex.

Dr. Urban Maes, Professor of Clinical Surgery in the Graduate School of Medicine of the Tulane University of Louisiana, attended the recent meeting of the American Surgical Association held at New Haven, Conn.

EYE, EAR, NOSE AND THROAT HOSPITAL.

Dr. J. Raymond Hume and Dr. Francis E. LeJeune have been elected as surgeons in charge of the ear, nose and throat department and Dr. M. Earle Brown was named surgeon in charge of the eye department of the Hospital.

INFECTIOUS DISEASES IN LOUISIANA.

Dr. J. A. O'Hara, State Board of Health of Louisiana, in collaboration with the Treasury Department of the United States Public Health Service, has issued the following weekly reports on the infectious diseases in the state. Abstracted these reports show the following: For the week ending April 23 there were reported 126 cases of syphilis, 86 of measles, 47 of gonorrhea, 27 of tuberculosis, 22 of cancer, 17 of diphtheria, and 18 of pneumonia. There were 14 cases of typhoid fever reported this week; also 3 cases of small pox and 3 cases of poliomyelitis. For the week ending April 30 the incidence of measles had fallen to 37 cases and syphilis to 36. The following diseases were reported in double figures: Twenty-eight cases of pulmonary tuberculosis; 25 of diphtheria, 19 of penumonia, 19 of influenza, 17 of typhoid fever, 13 of cancer, 12 of whooping cough, and 11 of gonorrhea. Five cases of small pox were reported, 1 of leprosy, and 1 of poliomyelitis. The succeeding week showed a marked increase in the number of cases of measles, 81 being reported this week, and an increase is noted also in the number of cases of syphilis and tuberculosis, 58 of the former and 42 of the latter being listed. Pneumonia had increased to 26 cases and typhoid fever to 19. Influenza had fallen to 13, diphtheria to 16 cases listed. In addition to the usual number of other diseases, it is noted that there were reported also 8 cases of small pox from the Parish of LaSalle, and 2 cases of poliomyelitis from Orleans Parish. For the nineteenth week of the year, which ended May 14, the diseases reported in largest numbers were as follows: Eighty-two of measles, 37 of syphilis, 32 of pneumonia, 31 of pulmonary tuberculosis, 27 of diphtheria, 26 of cancer, 13 of scarlet fever, 12 each of typhoid fever and whooping cough. Nine cases of small pox were reported, 5 of them originating in Iberia Parish. There was 1 case of poliomyelitis reported from Orleans Parish.

HEALTH OF NEW ORLEANS.

The Department of Commerce, Division of Vital Statistics, reports for the week ending April 16 a death rate for the City of New Orleans of 16.0 as a result of the deaths of 145 citizens of the City, 91 of whom were white and 54 colored. The infant mortality for this same week was 91, as a result of the death of 9 white and 7 colored children. For the week ending April 23 the death rate was 17.1, somewhat higher than the previous week. In this week there were 155 deaths, 97 among the white and 58 in the colored population. The infant mortality rate was only 57. The following week there was a slight decrease in the number of deaths, 137 occurring in this week, divided 84 white and 53 colored, with a death rate for the whole of 15.1, for the white 13.0 and for the colored 20.2. The infant mortality rate was 80. For the week ending May 7 the deaths had fallen to a total of 122, giving the low rate of 13.4. The 68 deaths in the white population gave a death rate of 10.5, while the 54 deaths among the colored gave a death rate in this race of 20.5. The infant mortality rate was 97. For the year 1932, eighteen weeks having elapsed, the death rate has been only 15.9, as contrasted with the same period of 1931 with the rate of 18.6. This rate incidentally for 1931 was considerably lower than in previous years.

WOMAN'S AUXILIARY NEWS.

ORLEANS PARISH.

The Woman's Auxiliary to the Orleans Parish Medical Society delayed their monthly May meeting from the second Wednesday until the fourth Wednesday of the month on account of the meeting of the American Medical Association which was held during that week, so the annual reports and election of officers will be printed in next month's Journal.

LOUISIANA STATE.

The Woman's Auxiliary to the Louisiana State Medical Society held its annual meeting and elec-

tion of officers Monday, May 9, at the Orleans Club. The President Mrs. W. S. Walther called the meeting to order, and the reports of the various standing committees were given. These showed that much progress had been achieved in all fields especially in those of organization and Hygeia.

The morning session was interrupted by luncheon where the guests of honor were some of the members of the National board, Mrs. McClothlan the president and Mrs. Walter Jackson Freeman the president-elect being among those present.

Mrs. S. M. E. Blackshear was toastmistress and was excellent in her presentation of our honored guests.

After luncheon the report of the presidents of the auxiliaries of the different parishes were presented. Then the Chairman of the nominating committee. Mrs. Herman B. Gessner of New Orleans, brought in the following slate which was accepted in whole.

The officers elected for the coming year read as follows:

President-elect—Mrs. John H. Musser, New Orleans.

First Vice-President—Mrs. George Kreeger, Lake Charles.

Second Vice-President—Mrs. W. J. Norfleet, Shreveport.

Third Vice-President—Mrs. J. B. Vaughan, Monroe.

Fourth Vice-President—Mrs. J. B. Benton, Minden.

Recording Secretary—Mrs. Francis Lejeune, New Orleans.

Treasurer—Mrs. Isidore Cohn, New Orleans.

Parliamentarian—Mrs. Charles Rew, Shreveport.

Mrs. Walthers then inducted Mrs. Lucas of Shreveport into office, who, after making a graceful speech asking for co-operation from all the parishes, ended up all old business and adjourned the meeting.

CADDO PARISH.

The Shreveport Auxiliary is again deserving of our deepest admiration for their wonderful editing of the Tri-State Journal, which put out an edition devoted entirely to a Survey of Auxiliary Work. It was compiled entirely by the Woman's Auxiliary and it is such a fine piece of work that I think all auxiliaries as a whole throughout the United States should be more than proud of the activities of the Women in the Shreveport Auxiliary.

Then too their report, which follows, is more than commendable:

An important part of the work of the Health Committee has been to secure dependable health programs for various organizations, and for the children of the schools. The Doctors of Shreveport have offered their services to go to any association and speak on health subjects. Many of the Parent Teacher's Associations have welcomed this offer and have requested health talks. Each member of the Committee has held herself responsible for the speakers for five of the city schools, thus providing speakers for twenty-five schools. The Chairman of "The Shreveport Medical Society" co-operates with us in finding the speaker most suitable for the subject and occasion.

Secondly the Health Program has been further carried out by furnishing each school library with an instructive pamphlet on Communicable Diseases. These pamphlets inform the layman of the symptoms, incubation period, how transmitted, prevention treatment and immunity of the most common of children diseases.

This Committee helped to seal Christmas health seals to the children of the schools; this money was given to aid the children of the Preventorium.

THE AMERICAN MEDICAL MEETING.

In New Qrleans for the first time a Woman's auxiliary has had the honour and pleasure of entertaining about 900 wives of the members of the American Medical Association. The pleasure of meeting and knowing so many from the different sections of our country has indeed been a keen inspiration. To sit in at the meetings and hear the quite marvellous reports of work done all over was a privilege that was indeed great.

The meeting was called to order in the Jerusalem Temple by Mrs. McGlothlan, with the invocation given beautifully by Bishop J. Craik Morris. The business was gone through with dispatch and then a buffet luncheon was enjoyed.

The afternoon was spent roaming through the Vieux Carre with guides pointing out the historical points and relating many interesting stories of New Orleans when in French possession, or in its Spanish aspect—ending up with tea at the Patio Royale, where we spoke to those we knew and also to those we did not.

Wednesday, business in the morning then to the lovely Southern Yacht Club for lunch, and almost best of all, the trips through the private gardens with tea at some hospitable house. The evening was pleasantly spent at the New Orleans Country Club, where we were enchanted by the dances which were so ethereally beautiful, by the spirituals which brought to us the soul of the Southern negro and finally, for as many of us who could by that time, dancing, with punch and sandwiches to refreshen.

Thursday morning meeting again, another luncheon and our choice of trips. The Oak alley plantation proved to be the most popular.

The reception and Presidents Ball was all that we had expected it to be.

Friday was devoted to a trip to the lovely gulf coast which was quite worth while seeing. And so the tenth meeting of the Woman's Auxiliary to The American Medical Association came to a pleasing end.

M. H. Musser.

MISSISSIPPI STATE MEDICAL ASSOCIATION NEWS

L. S. Lippincott, Editor
Jacob S. Ullman, Associate Editor *D. W. Jones, Associate Editor*

THAT WE MAY KNOW EACH OTHER BETTER.

Hubert Lowry Rush, M. D., was born at Meridian, July 16, 1897. He received his preliminary education in the Meridian public and high schools; his B. S. degree from the University of Mississippi in 1919; and his M. D. degree from the University of Pennsylvania in 1921. He was licensed to practice medicine in Mississippi in 1921. He married Miss Mary Geneva Hutson of McCall, on April 8, 1924, and has one son, H. Lowry, Jr.

HUBERT LOWRY RUSH, M. D.
Meridian, Mississippi,
Councilor, Sixth District,
Mississippi State Medical Association.

Dr. Rush has been surgeon on the staff of Rush's Infirmary, Meridian, since 1921; consulting surgeon of the East Mississippi Insane Hospital since 1929; visiting surgeon of the Matty Hersee Charity Hospital, 1924 to 1931; field examiner of the United States Veterans Bureau since 1921; and is local surgeon of the Gulf, Mobile and Northern Railroad. He spent two months in post-graduate work in European clinics in 1925.

Dr. Rush is a member of the East Mississippi Medical Society, having served as its secretary for six years, the Mississippi State Medical Association, the American Medical Association, Southeastern Surgical Congress, American Medical Editors and Authors Association, and the American Association of Industrial Surgeons and Physicians. He is a Scottish Rite Mason and steward in the Methodist church.

Associated with his brother, Dr. Leslie V. Rush, Dr. Rush operates Rush's Infirmary, a hospital of 52 beds. This institution is on the approved list of the American College of Surgeons. Dr. Rush limits his practice to general surgery.

CALENDAR.

June 1.—Claiborne County Medical Society, Port Gibson, 3 P. M.; Staff of Chamberlain-Rice Hospital, Natchez; Staff of Vicksburg Infirmary, 7 P. M.; Staff of Rush's Infirmary, Meridian, 7 P. M.; Staff of Dr. F. G. Riley's Children and Maternity Hospital and Clinic, Meridian, 7 P. M.

June 2.—Pike County Medial Society, McColgan Hotel, McComb, 7 P. M.; Staff of McRae Hospital, Corinth, 2 P. M.

June 3.—Natchez Medical Club, 1 P. M.

June 6.—Staff of Jackson County Hospital, 7:30 P. M.; Jackson County Medical Society, Jackson County Hospital, 7:30 P. M.; Staff of Meridian Sanitarium, 7:30 P. M.; Staff of South Mississippi Charity Hospital, Laurel, 7 P. M.; Staff of Geo. C. Hixon Memorial Hospital, Electric Mills, 8 P. M.

June 7.—Staff of King's Daughters' Hospital, Brookhaven, 7:30 P. M.

June 8.—Staff of King's Daughters' Hospital, Greenville, 7 P. M.; Harrison-Stone-Hancock Counties Medical Society, 7:30 P. M.

June 9.—Staff of Aberdeen Hospital, 8 P. M.; Staff of Vicksburg Hospital, 6:30 P. M.

June 10.—Staff of Anderson Infirmary, Meridian, 7 P. M.; Staff of Vicksburg Sanitarium, 6:30 P. M.

June 13.—Staff of South Mississippi Charity Hospital, Laurel, 7 P. M.

June 14.—Staff of Natchez Sanatorium, 7 P. M.; Issaquena-Sharkey-Warren Counties Medical Society, Y. M. C. A., Vicksburg, 7 P. M.; Staff of Tupelo Hospital, 7:30 P. M.; Winston County Medical Fraternity, Louisville.

June 16.—East Mississippi Medical Society, Neshoba County Fairgrounds, 2:30 P. M.

June 17.—Natchez Medical Club, 1 P. M.

June 20.—Staff of South Mississippi Charity Hospital, Laurel, 7 P. M.

June 21.—Northeast Mississippi Thirteen Counties Medical Society, Amory, 1 P. M.; Staff of Natchez Charity Hospital, 8 P. M.; Central Medical Society, Jackson, 7 P. M.

June 27.—Staff of South Mississippi Charity Hospital, Laurel, 7 P. M.

THANK YOU.

"I want to congratulate you on the Journal. I know the members are all proud of it."

R. M. Stephenson, Lexington.

LEFLORE COUNTY.

Jesse Robert Hightower, son of Dr. L. H. Hightower of Itta Bena, has been awarded one of the scholarships offered by the Commonwealth Foundation of New York, which enables him to take a four years' course in medicine at Tulane.

Ira B. Bright, son of the late Dr. Bright of this place, will serve his internship at Touro, after graduating at Columbia, New York.

Stirling Claiborne, son of Dr. Claiborne, the rector of the Episcopal church of this place, after graduating at the University of Virginia in May, will serve his internship at the Massachusetts General Hospital, Boston.

Fred Sandifer, son of Dr. F. M. Sandifer of this place, is studying medicine at the University of Chicago.

Gwin Mounger, of Greenwood, a nephew of Dr. John Darrington of Yazoo City, is studying medicine at Tulane.

Dr. Chas. L. Cooper of this place, a recent graduate of the University of Tennessee will serve his internship at the Hollywood Hospital in Hollywood, California.

Tate Carl of Greenwood is taking his course in medicine at the University of Tennessee.

W. B. Dickins, County Editor.

NESHOBA COUNTY.

Doctors who attended the State Medical Association Meeting at Jackson were W. R. Hand, W. H. Banks, Charlie Harrison, J. R. Plummer, and J. S. Hickman. Dr. J. S. Hickman was elected Vice-President from the middle district

Drs. W. R. Hand, L. A. Majure, W. H. Banks and J. S. Hickman attended the East Mississippi Medical Society meeting held in Meridian April 21, and all reported one of the best meetings ever held. Dr. Sidney K. Simon of New Orleans, was the pinch-hitter of the program.

The meeting of the East Mississippi Society will be held at the Neshoba County fairgrounds June 16 at 2:30 P. M. We are expecting a very interesting program, eats, etc.

Dr. Charlie Harrison has been sick the past week with an infected hand. The report we are glad to say is that he is very much improved.

Dr. J. Stribling is still very actively engaged in his profession. However, he just has to get off occasionally and try out his twenty-five hounds fox hunting.

Dr. W. L. Watkins spends his spare time from his practice farming.

Drs. Claude Yates and M. E. Cole go fishing when they can find the time and forget all about the depression. I feel like the writer is going to join them.

Dr. J. R. Plummer keeps too busy seeing after two saw mills to be seen anywhere else except on the road between the two mills.

Drs. L. A. Majure and W. H. Banks are in the rural part of the county and for some reason they are staying away from our little city, however, both are very busy doctors.

Drs. W. R. Hand and J. S. Hickman had the misfortune to have their Ford cars stolen. We have decided that it is cheaper to drive our wives' cars as we do not have the wherewiths to get another one, and, too, when the roads are bad and also the pay, we do not have a way to go. We are not so fortunate as our governor, Mike Conner, who had his stolen one day and the next day it was found in Atlanta, Georgia.

J. S. Hickman, County Editor.

WINSTON COUNTY.

We are having extremely healthful conditions through this county. Doctors are really tired of resting.

Dr. C. L. Richardson reports a fine catch of brim recently on a fishing trip. He was a little jealous of his boys who beat him in the catch.

Some of our doctors attended the State Medical Association at Jackson recently. Among them were Drs. T. F. Kilpatrick and W. H. Hickman. Others together with the writer intended going but were prevented by a few cases in charge.

We commend Dr. Bernard Hickman for the reputation he is making playing bridge. This is fine. We wish him all the thrills that go with the game.

Dr. S. W. Pearson took a patient to a Jackson Hospital recently.

We are looking forward with interest to a treat from Dr. W. W. Parks who speaks on Child Clinic at the Rotary tomorrow.

W. L. Montgomery, County Editor.

PIKE COUNTY.

The Commonwealth Fund has contributed $650.00 to the Pike County Medical Society to be

used in getting men of outstanding ability to visit the society and hold clinics. Dr. Chas. Bloom, New Orleans, and Dr. John G. Carr, Chicago, have been our guests recently.

The following members of the Pike County Medical Society attended the meeting of the State Association in Jackson: Drs. Thomas Purser, D. T. Brock, M. D. Ratcliff, G. W. Robertson, T. E. HeWitt, R. H. Brumfield.

Dr. W. M. Biggs, Osyka, has returned from Baltimore where he went to consult eye specialists in regard to being operated on for cataracts.

Dr. J. M. Smith, Magnolia, and Dr. W. C. Hart, McComb, have returned from a four months' postgraduate course at Tulane.

Dr. H. C. Hatcher, secretary, has resigned and moved to Baton Rouge, La. Dr. Hatcher will be associated with the Standard Oil group in his new location.

Robert H. Brumfield.

MONROE COUNTY.

Your correspondent was greatly disappointed in that he did not get to attend the recent meeting of the State Association. It was the second time in over twenty-five years that I have missed. This time it was because I was sick, the other time because of sickness in another member of my family. How I did want to be with you and all my friends. This disappointment was made easier to bear by the receipt of a telegram from the Association, telling me that I was missed. Several of my friends wrote me expressing regret at my sickness and absence. But of all the kindly messages received, the one most appreciated, perhaps, was a letter from the wife of one of my dearest friends. I want her and him to see this public acknowledgment of my appreciation. I was delighted to know that it was such a splendid meeting—the program was fine, indeed, and I am sure the fellowship was most enjoyable to all in attendance.

I was much pleased to learn that Dr. Dicks was selected as president-elect. Dr. Dicks is so capable of reflecting honor on the Association and withall is so deserving of the honor bestowed on him. Of course, one cannot see all his friends honored at one time but honors usually come to the deserving and to those who wait.

The Thirteen Counties Society will hold its next regular quarterly meeting in Amory on Tuesday, June 21. Everybody is invited to be present and see a real society in action. Especially, do I want some of my friends from other parts of the state to come. To any one who counts himself my friend, I send this special invitation.

Dr. C. E. Boyd of Hatley, our most recent ex-president, has been indisposed recently but I feel sure he is quite well by now. Mrs. Reed, the wife of Dr. W. N. Reed of Amory, spent last week in hospital because of the necessity for some minor surgery. I am glad to report that she is back at home and practically well again.

I had planned to go to New Orleans to attend the meeting of the American Medical Association, but had to forego this pleasure because of some professional obligations that could not well be shifted. I, again, had to miss friendly greetings from those I love to meet.

Do not forget the time and place—Amory, June the twenty-first. A good meeting and a hearty welcome is promised.

G. S. Bryan, County Editor.

EAST MISSISSIPPI MEDICAL SOCIETY.

The East Mississippi Medical Society met in the Lamar Hotel, Meridian, Thursday, April 21. Forty-nine members and eleven guests were present.

A brief report was given by delegates, Drs. M. J. L. Hoye and T. F. Kilpatrick, in regard to the State Medical Association meeting in Jackson.

Dr. C. R. Stingily, Chairman of the Committee on a Medical Conference, reported that the committee was still at work on plans for the conference.

On motion by Dr. W. H. Banks, a message of sympathy was sent to Dr. S. A. Majure, in the recent loss, by death, of his daughter, and illness in his family. Through suggestion by Dr. T. H. Cleveland this message was delivered by Dr. Dudley Stennis.

Dr. S. A. Majure was lauded for his services to the society and on motion by Dr. W. H. Banks was voted an honorary member.

The following program was rendered:

1. Meningitis.—Dr. D. L. Walker, Meridian.

Discussed by Drs. T. D. Boudreaux, T. K. Kilpatrick, and A. C. Bryan.

2. Achalasia of the Esophague, with Presentation of two Successfully Treated Cases.—Dr. Sidney K. Simon, New Orleans, La.

Discussed by Drs. W. J. Coleman, D. L. Arnold, T. D. Bourdeaux Leonard Hart, and J. S. Hickman.

3. Injection Treatment of Hemorrhoids.—Dr. W. B. Hickman, Louisville, Miss.

Discussed by Drs. R. G. Hand, H. H. Robinson, T. K. Kilpatrick, Willie Walley, A. C. Bryan, and W. H. Banks.

Just before closing the Society received a welcome surprise, in an invitation by the Neshoba County doctors for the next meeting to be held on the Neshoba County Fairgrounds, June 16, where barbecued meat and refreshments are to be served. The wives of doctors were also cordially invited.

T. L. Bennett, Secretary.

REPORT OF BUREAU OF COMMUNICABLE DISEASES.

The Bureau of Communicable Diseases of the Mississippi State Board of Health reports for the month of March, 1932, typhoid fever, 26 cases; smallpox, 164 cases; diphtheria, 55 cases; scarlet fever, 58 cases; pellagra, 385 cases; tuberculosis, 114 cases. Reports for the month were received from 98.2 per cent of physicians.

THE EX-PRESIDENTS CLUB.

One of the interesting side-lights of the State Medical Association meeting was the annual banquet of the ex-presidents. This took place at 12:30 on Wednesday in the Tea Room of the Robert E. Lee Hotel, where an excellent chicken dinner was served. The chairman presides in the order of sequence. Dr. D. J. Williams of Gulfport, president in 1912, was the presiding officer. After dinner, Dr. Williams called on a few of the members for remarks beginning with Dr. P. W. Rowland, Oxford, president in 1895, and the oldest member present. Dr. Rowland has been a member of the State Medical Association for 49 years, and has attended nearly every meeting. Four years ago at the organization of this club, he issued a challenge to the ex-presidents to meet him every year for the next ten years. He certainly looks good for the balance. Chairman Williams next called on Dr. John C. Culley of Oxford, as the youngest ex-president, his term of office expiring with this meeting. Dr. Culley is an old Jackson boy, son of our Dr. B. L. Culley, and has made good as an executive officer of the association. Dr. W. S. Leathers, formerly dean of the Medical Department of the University of Mississippi, and for many years executive officer of the State Board of Health, now dean of the Medical Department of Vanderbilt University, was next called upon and made a very enjoyable talk. Dr. James M. Acker, President-Elect, whose administration begins at the close of this meeting, was next called. He expressed his appreciation for the honor conferred upon him and asked the advice and assistance of his fellow club-men in carrying out the work of the new year. Another veteran, Dr. H. H. Haralson of Vicksburg, president in 1896, was called on and responded with some reminiscences of former days.

This is the fifth meeting of the Ex-Presidents Club, which has shown a remarkable attendance, the last three years showing the high water mark of 80 per cent present. Considering their ages and residences in many states, this certainly is a remarkable showing of continued interest on the part of the ex-presidents, and should be an example well worthy of emulation by the younger members.

The following members were present: Drs. P. W. Rowland, H. H. Haralson, C. D. Mitchell, W. W. Crawford, D. W. Jones, D. J. Williams, J. S. Ullman, T. M. Dye, Willis Walley, W. S. Leathers, F. J. Underwood, J. W. Barksdale, Henry Boswell, S. W. Johnston, W. A. Dearman, John Darrington, W. H. Frizell, John C. Culley, Jas. W. Acker.

D. W. Jones.

OUR LAST STATE MEETING.

Many complimentary remarks were heard among the members and guests anent our recent meeting. Many went so far as to say that it was the best all-round meeting they ever attended. The programs were well arranged with high class papers and spirited discussions, not too long. President Culley dispatched business with expedition, and to the entire satisfaction of all. The arrangements by the local committee were as nearly perfect as possible, and received the warm endorsement of everyone present. The Women's Auxiliary, in a quiet way, made the visiting ladies feel at home, and gave them a good time. The tea and dance to the membership was a most enjoyable affair. The several special luncheons were most profitable and enjoyable.

On the whole, it was one of the best meetings we have had, and we promise the boys another still better next year. D. W. Jones.

WOMEN'S AUXILIARY TO THE ISSAQUENA-SHARKEY-WARREN COUNTIES MEDICAL SOCIETY.

A regular monthly meeting of the Women's Auxiliary to the Issaquena-Sharkey-Warren Counties Medical Society had a most enjoyable luncheon meeting Tuesday, April 19, at the Hotel Vicksburg, with twenty-one members present. Mrs. H. S. Goodman, Cary, vice-president, presided.

Mrs. W. H. Parsons, Vicksburg, played several piano selections, Mrs. L. E. Martin, Anguilla, read a one-act playlet, "What Every Woman Knows," with apologies to Sir James Matthew Barrie.

Mrs. Leon S. Lippincott made a report on the state meeting held in Jackson. Mrs. H. H. Haralson, Vicksburg, was appointed to have charge of the program for National Child Health Week. Mrs. A. Street, Vicksburg, explained the Jane Todd Crawford Memorial Work, in which each Auxiliary is to put on a program during the year.

The matter of health conditions and treatment for colored servants with venereal disease was discussed.

A luncheon meeting of the Auxiliary will be held in May after which there will be no regular meeting until September.

Ada R. Bell, Secretary.

JACKSON COUNTY.

At a regular meeting of the staff of the Jackson County Hospital held Monday evening, May 2, the following members were present: Drs. Rape, McArthur, Lander, Lockard, Eley, Gray and McIlwain.

The report of the hospital for the month of April was read and discussed.

A round table discussion of the diseases causing deaths in the hospital in April was the program, being pneumonia, puerperal eclampsia, and cardio-renal disease.

Drs. R. G. Lander and J. N. Lockard were appointed to draft a set of by-laws for the staff.

Dr. J. N. Lockard made a business trip to Baltimore recently.

Miss Emma Lou Lander, daughter of Dr. and Mrs. R. G. Lander, was a member of the 1932 graduating class of the Pascagoula High School. Dr. Lander says the hat will have to be passed if she attends college this fall.

R. B. and Fannie Pearl, students at "Ole Miss," spent a few days with their parents, Dr. and Mrs. S. B. McIlwain, being accompanied by a guest, Miss Margaret Price of Oxford, who is a niece of our good friend, Dr. W. S. Leathers.

S. B. McIlwain, County Editor.

LOWNDES COUNTY.

Dr. Ped L. Fite of the Fite hospital and Dr. Eli Staton of the Columbus Hospital staff were the local representatives of the medical profession at the meeting of the Mississippi State Medical Association. Dr. Staton read a paper in the Eye-Ear, Nose and Throat Section.

Dr. C. B. Mitchell, resident surgeon, Mississippi State College, Starkville, who recently underwent an operation for appendicitis at Fite hospital has returned to his home for convalescence.

Dr. C. D. Mitchell, superintendent of the Insane Hospital, Jackson, with his family, visited his son, Dr. C. B., while he was confined to Fite hospital following his operation for appendicitis.

At the annual May Day program which will be held in the city of Columbus, Wednesday, May 4, health induced by preventive measures will be stressed. There will be a parade through the business district at 2:30 o'clock, ending at the campus of the Barrow Memorial School with an open air program, designed to bring home to parents the value and need of giving the child every means of health protection. Honorable Birney Imes, editor of the Columbus Commercial Dispatch, will be the master of ceremonies and will introduce Dr. J. W. Dugger of the field force of the State Board of Health, who will be the speaker of the day. There will be two brass bands. A varied program will be given by the students of the city schools.

J. W. Lipscomb, County Editor.

HONORARY MEMBER.

The list of honorary members elected by the Mississippi State Medical Association at its recent meeting, and published last month, should have included the name of Dr. W. H. Aikman of Natchez. Dr. Aikman was proposed by the Homochitto Valley Medical Society and was unanimously elected.

PONTOTOC COUNTY.

The physicians of the county report health unusually good. We all have plenty of time to go fishing.

The Northeast Mississippi Medical Society meets June 14 at Amory. Let's go.

R. P. Donaldson, County Editor.

DR. ROBERT ROWLAND.

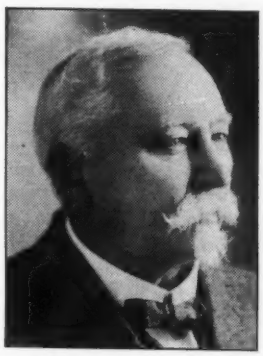
Dr. Robert Rowland, died recently at the Mississippi Tuberculosis Sanatorium, after a long illness.

Dr. Rowland was born and reared at Flora, Madison County, son of Dr. Robert W. Rowland. He received his medical degree from Tulane University and at once engaged in field work with the Mississippi State Board of Health when the activities of that organization were in their infancy.

About fifteen years ago Dr. Rowland located in Jackson for the practice of his profession, and there married Miss Mary Hamilton, daughter of the late J. S. Hamilton.

Dr. Rowland is survived by his widow, aged mother, Mrs. Robert Rowland, Sr., two brothers and one sister, the latter residents of Flora.

PAST PRESIDENTS—LEST WE FORGET.



J. W. YOUNG, M. D.
Grenada, Mississippi.
President, Mississippi State Medical Association
1910-11.

John William Young was born October 27, 1846, in what was then part of Carroll, now Montgomery County, Mississippi. His father, Samuel Hart Young, was from Albermarle County, Virginia; his mother, who was Catherine W. Small, was from Tipton County, Tennessee. Both were early settlers in Carroll County, somewhere in the thirties. Dr. Young attended the "old field schools" of that day and time up to June, 1863, when he entered the Confederate army, under Forrest. He was captured at Salem, Ala., April 1865, by Wilson's command in Forrest's last fight, was paroled at Columbus, Ga. April 10, and returned from there to Carroll County and went to work on the farm, studying medicine in his leisure moments. He entered Tulane University in the fall of 1867 and graduated from there in March 1869, settling in his native county, where he practiced until January 1890, moving thence to Grenada.

On February 20, 1873, Dr. Young married Miss Molly L. McCain of Carroll County, whose ancestors were North Carolinians and whose father was president of a female college at Columbus, Miss., somewhere in the fifties.

Dr. Young was a member of the "Ku Klux Klan" during the reconstruction period and did his dead level best to get the "negro's feet off the white man's neck." He was chairman of the Democratic Executive Committee of Carroll County from 1882 to 1890 and chairman of the County Prohibition Executive Committee. In 1888 he was delegate from his Congressional District to the Democratic National Convention; that which nominated Mr. Cleveland for his second term. He is a member of the A. M. A., of the Winona District Medical Society, of the American Association of Railway Surgeons, of the Joint Association of I. C. and Y. & M. V. and Indianapolis Southern Railway Surgeons and has been a member of the Mississippi State Medical Association since 1877. He served as delegate from the State Association to the American Medical Association in 1912 and in 1913, and was vice-president of the State Association 1906-7.

Almost totally disabled for many years, his time is now spent "reading and smoking and living in the past," largely in those days when, serving under Forrest, he "felt that he perhaps was justified in keeping well to the front, but found that it required constant concentration to keep his legs moving in the right direction." On the occasion of his eighty-third birthday he was given a dinner by the doctors of his county and presented with a meerschaum pipe, and the following year the officers of the Presbyterian Church gave a dinner in his honor and presented him with a loving cup.

TATE COUNTY.

You no doubt wonder why you never hear from Tate any more often. The truth is, we have very little to report. We have had very little sickness as a whole, to the joy of the doctors of this county, no hospitals, and very few meetings of our society for some months past. However, we had our regular meeting of the Tate County Medical Society last night, with very few present. We were to discuss whether we would continue on as a county unit or join with other counties in a larger society, but so few members were present, we decided to postpone this until a later date.

Our officers for the year are:

Dr. M. M. Powell, Coldwater, President.

Dr. L. L. Wilborn, Senatobia, Vice-President.

Dr. J. S. Eason, Coldwater, Secretary.

Dr. H. L. Murphy, Arkabutla, Delegate to Mississippi State Medical Association.

Our delegate did not get to go to the meeting of the Mississippi State Medical Association at Jackson. Our only men to attend were Drs. Smith, and Byers of Senatobia, who report a good meeting and well worth attending.

I agree with so many of our physicians in regard to our charity hospitals. We should have a change and have either county or two-county units, well equipped, and the state care for only the real charity. We cannot get a patient to our charity hospitals now very well, and not at all if it is an emergency case. We have imposed on the Memphis hospitals until we are no longer welcome as in the past, and we cannot blame them. Mississippi should take care of her own charity. The northern half of Mississippi has to pay her full share of taxes. Then why should practically all of the money spent go to the southern half for charity hospitals?

J. Sidney Eason, Secretary.

MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

The following Mississippi doctors registered at the meeting of the American Medical Association in New Orleans on May 9, 10, 11, 12, and 13: G. L. Arrington, Meridian; L. B. Austin, Rosedale; C. C. Buchanon, Hattiesburg; C. E. Catchings, Woodville; L. J. Clark, Vicksburg; B. R. Clark, Lorman; L. C. Davis, Greenville; H. A. Gamble, Greenville; E. C. Gillespie, Lambert; S. L. Hollingsworth, Columbus; W. E. Johnston, Vicksburg; E. H. Jones, Vicksburg; L. S. Lippincott, Vicksburg; W. I. Marsalis, Centreville; W. W. McRae, Corinth; P. L. Mull, University; S. Myers, Vicksburg; J. E. Quidor, Vicksburg; D. G. Rafferty, Pass Christian; T. E. Ross, Jr., Hattiesburg; J. D. Simmons, Gunnison; P. E. Smith, Hattiesburg; T. J. Smith, Meridian; M. M. Snelling, Gulfport; W. L. Stallworth, Columbus; G. M. Street, Vicks-

burg; A. G. Touchstone, Meridian; N. C. Waldrep, Tichomingo; G. H. Wood, Batesville; H. L. Arnold, Meridian; G. W. Aubanks, Greenville; W. J. Anderson, Meridian; R. B. Austin, Forest; O. H. Beck, Greenville; E. N. Blount, Bassfield; R. H. Cranford, Laurel; W. W. Crawford, Hattiesburg; J. P. Culpepper, Jr., Hattiesburg; J. C. Culley, Oxford; S. E. Field, Centreville; G. E. Godman, Poplarville; A. Van Dyke Hagaman, Jackson; R. B. Harper, Fayette; A. B. Harvey, Tylertown; Paul Jackson, Liberty; S. B. McIlwain, Pascagoula; J. L. Melvin, Shuqalak; L. B. Morris, Macon; E. R. Nobles, Rosedale; W. H. Parsons, Vicksburg; C. W. Patterson, Rosedale; L. L. Polk, Purvis; D. G. Rafferty, Pass Christian; F. E. Rehfeldt, Jackson; G. M. F. Rembert, Jackson; A. R. Robertson, Pass Christian; R. E. Schwartz, Hattiesburg; W. C. Simmons, Foulke; F. F. Smith, Crystal Springs; H. P. Smith, New Augusta; I. B. Trapp, New Albany; E. A. Trudeau, Biloxi; F. L. Van Alstine, Jackson; G. W. Wallace, Biloxi; J. E. Wallace, Biloxi; P. E. Werlein, Biloxi; W. J. C. Weimers, Sanatorium; Temple Ainsworth, Jackson; C. C. Applewhite, Jackson; J. G. Archer, Greenville; O. N. Arrington, Brookhaven; T. T. Batson, Hattiesburg; S. E. Bethea, Hattiesburg; Marcus Beekman, Natchez; W. N. Blount, Laurel; J. W. Brandon, Woodville; R. H. Brumfield, McComb; J. J. Carter, Biloxi; R. H. Clark, Hattiesburg; W. J. Coleman, Meridian; F. E. Collins, Brookhaven; H. G. Cook, Hattiesburg; I. W. Cooper, Meridian; H. T. Cuming, Pace; John Darrington, Yazoo City; W. A. Dearman, Gulfport; O. G. Eubanks, Crystal Springs; H. R. Fairfax, Brookhaven; R. W. Hall, Jackson; Leonard Hart, Meridian; C. C. Hightower, Hattiesburg; J. B. Howell, Canton; D. W. Jones, Jackson; T. W. Kemmerer, Jackson; Charles LeBaron, Gulfport; L. W. Long, Jackson; J. F. Lucas, Greenville; E. P. Odeneal, Gulfport; Thomas Purser, McComb; D. A. Ratliff, Columbia; G. Russel, Jackson; R. S. Savage, Brookhaven; J. W. Shackelfield, Greenville; Charles A. Sheely, Gulfport; A. P. Smith, Bay St. Louis; R. C. Smith, Drew; E. B. Van Ness, Gulfport; W. H. Watson, Pelahatchie; B. L. Welch, Biloxi; N. C. Womack, Jackson; R. B. Zeller, Jackson.

ISSAQUENA-SHARKEY-WARREN COUNTIES MEDICAL SOCIETY.

The regular monthly meeting of the Issaquena-Sharkey-Warren Conuties Medical Society was held at the Y. M. C. A., Vicksburg, May 17, with 23 members and one visitor present. Dr. H. S. Goodman, Cary, President, presided.

The Scientific program was as follows:

1. Actinomycosis in Children.—Dr. Rollin E. Cutts, Vicksburg. Discussed by Drs. W. H. Parsons, L. S. Lippincott, and H. S. Goodman. Dr. Cutts closed.

2. A Few Diagnostic and Prognostic Thoughts Relating to Tuberculosis.—Dr. F. M. Smith, Vicksburg. Discussed by Drs. W. G. Weston, W. H. Scudder, J. A. K. Birchett, Jr., H. H. Haralson, J. B. Benton, and S. W. Johnston. Dr. Smith closed.

3. The Heart in Thyroid Diseases.—Dr. L. J. Clark, Vicksburg. Discussed by Dr. H. S. Goodman and G. M. Street. Dr. Clark closed.

Dr. Rollin E. Cutts, Vicksburg, was unanimously elected to membership in the Society.

Dr. H. S. Goodman, for the doctors of Sharkey County and their wives, invited the Society to meet in Cary for the July meeting. The invitation was enthusiastically accepted.

The next meeting of the Society will be held at the Y. M. C. A., Vicksburg, on Tuesday, June 14, at 7 p. m. The committee in charge of the program consists of Dr. G. P. Sanderson, Vicksburg, Chairman; Dr. G. W. Gaines, Tallulah, La.; and Dr. J. S. Ewing, Vicksburg.

MARSHALL COUNTY.

Dr. J. B. Bailey has moved from Byhalia to Clyde, Texas, and will take over his brother's practice there.

Dr. D. R. Moore, Byhalia, has returned from New Orleans where he has just finished a four months' postgraduate course of study in Tulane University. This fellowship scholarship was awarded him from the Commonwealth Fund of New York, and his appointment was one of five from the State of Mississippi.

D. R. Moore, County Editor.

NURSE-O-GRAMS.

A very attractive little booklet entitled "Nurse-O-Grams," issued by the Natchez Charity Hospital, has been received. This contains the names of the faculty of the nurses' training school, the board of trustees of the hospital, a page of nursing history, and numerous other interesting items. It is a credit to the hospital and to the school.

HONOR ROLL.

The following have contributed to this issue of the Journal: F. M. Acree; O. H. Beck; Lawrence W. Long; G. C. Jarratt; H. Lowry Rush; R. M. Stepsenson; W. B. Dickins; J. S. Hickman; W. L. Montgomery; R. H. Brumfield; G. S. Bryan; T. L. Bennett; D. W. Jones; Ada R. Bell; S. B. McIlwain; J. W. Lipscomb; J. S. Ullman; R. P. Donaldson; E. F. Howard; J. Sidney Eason, D. R. Moore 21. Thank you.

BOOK REVIEWS

Diseases of the Kidney: By W. Girling Ball, F. R. C. S. (Eng.), and Geoffrey Evans, M. D. (Cantab.), F. R. C. P. (Lond.). Philadelphia, P. Blakiston's Son & Co., Inc. 1932. pp. 424.

The need of a monograph such as that presented by Ball and Evans cannot be fully appreciated until the book is read carefully. The usual thoroughness that is met with in British medical literature is presented in this work. The illustrations number 169, and are of the higher type.

The Signs and Symptoms of Renal Diseases are very thoroughly presented, and the ways and means of examining a urinary case are set forth with perfect thoroughness. Intravenous urography is properly stressed, and the renal function tests are accorded due recognition, inclusive of the phthalein test which is usually ignored by European writers.

Congenital lesions of the kidney and ureter are dealt with fully. Polycystic diseases of the kidney are stressed both in text and by excellent illustrations. Variations in the renal pelvis and ureter are given due consideration. Their attitude toward movable kidney is most sane; they reserve fixation in these cases where all supportive means of relief have failed.

The book contains 8 colored plates and several of these are well worth careful study. Pyelography is heartily endorsed by the authors as a means of more accurately determining the degree of pathology suspected in the upper urinary tract. There are 74 pages devoted to nephritis—more space by far than one usually finds in a treatise devoted primarily to surgical ailments of the kidney.

For the physician beginning the practice of urology, this work of Ball and Evans will certainly furnish an excellent reference. The general surgeon will find much in the way of references to surgical literature of value in studying obscure conditions. The only real criticism we find in the work occurs in the chapter on operative procedures on the kidney; this chapter being utterly devoid of illustrations.

H. W. E. WALTHER, M. D.

The Insanity Plea: By Edw. Huntington Williams, M. D. Baltimore, Williams & Wilkins Co. 1931. pp. 169.

Brings out a number of points which are quite familiar to all of us who have anything to do with psychiatric work in the courts, and points out a number of the more glaring shortcomings of our judicial system in dealing with the mentally-ill offender against the law It would be a good book for all lawyers, judges or district attorneys to read if they would thoroughly digest the subject-matter. It is clearly written more for lay consumption than for trained physicians. However, a great many physicians not trained in psychiatry could benefit materially by reading it, as it would probably bring home to them what it means to qualify as an expert in conditions which they know nothing about. It therefore has a distinct place in the medical library.

E. MCCONNELY, M. D.

Surgical Errors and Safeguards: By Max Thorek, M. D., with a Foreword by Arthur Dean Bevan, M. D. Philadelphia, J. B. Lippincott Co. 1932. pp. 696. Price, $10.00.

The author gives to the surgeon knowledge that one may acquire only by way of that long road called experience. He delves into the details of surgery which so many writers overlook and thereby avoids courting trouble. In reading through this book one's interest is increased in seeing that others have encountered experiences similar to one's own. The facts are ably collected and unlike other surgical textbooks this author omits what is discussed elsewhere and vice versa. The book is divided into 16 chapters and the illustrations are chosen from the texts of accredited authors. The chapter The Pancreas is very good and brings the subject up to date. The succeeding chapter of Herniæ makes no mention of congenital sliding hernia, which the reviewer thinks should be included. There are special chapters on Genito-Urinary and Gynecological surgery. The book is well compiled, it contains a great amount of material and could only have been written by a man of vast experience.

EMILE BLOCH, M. D.

Naissance, Vie et Mort de Maladies Infectieuses: By Charles Nicolle. Paris, Félix Alcan. 1930. pp. 219.

As scientifically accurate as could be desired of a book intended for the intelligent layman, the volume reviewed here deserves particular commendation because the author well accomplishes his desired end in giving in plain yet beautiful language the life history of the infectious diseases.

CHARLES MIDLO, M. D.

The Nurses Medical Lexicon: By Thomas Lathrop Stedman, A. M., M. D. New York, Wm. Wood Company. 1931. pp. 629.

The author intends this dictionary for the student nurse as well as for the experienced graduate and for others outside the nursing profession, particularly for Red Cross and public

health workers and those who are associated with physicians are dentists.

There is an appendix which deals with weights and measures, comparative temperature scales, poisons and antidotes, and time tables of infectious diseases. Illustrations are lacking, but the beautified cover will, unquestionably, delight the possessor of the useful book.

CHARLES MIDLO, M. D.

Medicine in Virginia in the Eighteenth Century: By Wyndham B. Blanton, M. D. Richmond, Garrett & Massie, Inc. 1931. pp. 449. Price, $7.50.

On first sight of Dr. Blanton's book the reviewer was surprised that anyone could write such a big book about medicine in one state between the years 1700 and 1800. Anyone reading the book soon becomes aware that years of painstaking research have uncovered such a wealth of valuable and interesting information that the author probably felt that the necessity for condensation involved hardship. The work is an important contribution to the history of medicine in terms of its fundamental and broad phases, such as medical education, character of practice and hospitals, and at the same time it is a valuable reference book for the histories of individual physicians of the times. Some of the lists of names of physicians of the period will be skipped by the average reader but scanned eagerly by the few.

The book has evidences of scholarship throughout and makes fascinating reading if one skips judiciously. It should be read widely by physicians, medical students and by laymen with interests in medicine and history. The description of medicine on the slave plantations is an especially important contribution. That Thomas Jefferson and other laymen of the period were more learned in medicine than the average physician of the time will shock many who are unaware of the low state of physic during that period. The contribution to the American history of smallpox and vaccination should be widely read by the profession and the laity. The state of medicine, surgery and hospitals during the Revolutionary War suggest that there is such a thing as progressive medicine. Dr. Blanton has discovered a number of individuals of outstanding merit and interest who have been neglected by previous historians.

R. H. TURNER, M. D.

The History of Medicine: By Bernard Dawson, M. D. (Lond.), F. R. C. S. (Eng.). New York, The Macmillan Company. 1932. pp. 160. Price $2.50.

This little volume of one hundred and fifty pages represents an attempt on the part of the author to set forth the milestones in the present day inheritance of medicine, in a manner which will interest and stimulate medical students. It is written in a delightful narrative style of which the following quotations is typical. "In Asia Minor, the cradle of early civilization, there is a river called the Meander which pursues a tortuous and circuitous course from its origin to the sea. It is from the name of this stream that we derive our verb 'to meander'—to wander hesitatingly over a devious and uncertain way. So were the beginnings of the science and art of medicine." Another very pleasant feature of the book is that the outstanding characters are presented as individual personalities rather than abstract figures as is usually done. Perhaps the chief fault of the whole volume lies in the fact that, in the author's attempt to achieve briefness, he has omitted much which could well have been included in a work of this kind.

BRUCE WEBSTER, M. D.

Confessio Medici: By Stephen Paget, F. R. C. S., New York, The Macmillan Company. 1931. pp. 158.

The publishers have at last awakened to the responsibility and necessity of again presenting Stephen Paget's *Confessio Medici* to the American physician. This volume, a medical classic if ever there was one, deserves a privileged place in every physician's library, alongside the works of Osler and other humane medical philosophers. The ten essays and the epilogue have much in them for every doctor, be he intern or octogenarian.

Stephen Paget writes with a beauty and logic that could well be emulated by all medico-literary physicians; his work reads with the fascination and swiftness of fine modern journalism. Particularly commendatory is his sketch on Paré.

Read *Confessio Medici;* try to leave it unfinished, if you can; see if you won't read it again and again; and then try to avoid owning it.

M. MALLOWITZ, M. D.

The Foundations of Medical History: By Sir D'Arcy Power, K. B. E., F. R. C. S. (Eng.) Baltimore, The Williams & Wilkins Company. 1931. pp. 182.

Sir D'Arcy Power will be remembered by many readers for his excellent short studies of eponyms and illnesses of renowned historical figures. In England he has been one of the outstanding leaders in propagating the study of medical history along with Osler, Allbutt, and Rolleston.

It was natural that he be invited to the Institute of Medicine at Johns Hopkins as visiting lecturer in 1930. During that time Sir D'Arcy delivered the six lectures which are embodied in this volume.

The lectures are a fine contribution to medical scholarship and should appeal to the physician in-

terested in historical research. The story of St. Bartholomew's Hospital should be of interest to all physicians.

M. MALLOWITZ, M. D.

Text-book of Clinical Neurology: By Israel S. Wchsler, M. D. 2d ed. rev. Philadelphia, W. B. Saunders Co. 1931. pp. 759.

The second edition of this excellent work on clinical neurology, divided into five parts, each complete in itself, has made its appearance and is filling a long felt want in the real of neurophsychiatry.

In the parts necessary, there has been revisions made, in others an elaboration, keeping in mind the trends of scientific medical progress.

It is essentially necessary that each neurologist familiarize himself with this text book. It likewise would make substantial collateral reading for the general practitioner and other physicians who wish to keep abreast of the times.

WALTER J. OTIS, M. D.

Gynecology and Urology for Nurses: By Samuel S. Rosenfeld, M. D., F. A. C.S. New York, Wm. Wood Company. 1931. pp. 230.

In this book the author has attempted to emphasize what the nurse needs most to know so as to attend intelligently the gynecological patient. He has well succeeded in his endeavor. Six succinct accounts of the anatomy, physiology, and pathology of the femal genito-urinary system are followed by well organized descriptions of the nurse's side of examination, non-operative measures, and operative procedures. The various instrument sets for gynecological operation are pictured. The illustrations are well chosen, and in large part do illustrate.

CHARLES MIDLO, M. D.

Walter Bradford Cannon: Exercises celebrating 25 years as George Higginson Professor of Physiology, Oct. 15, 1931. Cambridge, Harvard Univ. Pr. 1932. Por. pp. 94.

The exercises celebrating Dr. Cannon's 25 years as Professor of Physiology at Harvard comprise interesting and entertaining papers by Drs. Edsall Alvarez, Howell and Lusk with reply by Dr. Cannon. His Who's Who and Bibliography are appended.

I. L. ROBBINS, M. D.

Intracranial Tumors: Notes upon a series of two thousand verified cases with surgical mortality percentages pertaining thereto: By Harvey Cushing. Springfield, Ill., Chas. C. Thomas. 1932. pp. 150. Price, $5.00.

More than once the writer has been set to the task of "reviewing" a book or paper from the masterful pen of Dr. Cushing; a difficult task indeed as the reviewer finds practically no chaff to separate from the wheat. As concerns style, force and diction it need only to be pointed out that the author is distinguished, uniquely among medical men, by being a winner of the Pulitzer Prize in Letters.

The present book is small (147 pages) but encompassed therein is data resulting from thirty years of intensive study, most of which was original, based upon a series of two thousand verified intracranial tumors, practically all of which were true neoplasms. The foundation of the work is histology, normal and otherwise, and the discussions are grouped about the cytology of the various lesions. Examination, diagnosis, localization and surgical technic receive scant attention. The tumors are grouped and discussed under twelve divisions; glimoas, pituitary adenomas, meningiomas, acaustic, congenital metastatic and invasive, granulomatous and blood vessel tumors, primary sarcomas, papillomas of the choriod plexus and miscellaneous tumors. There are chapters on Primary Case Subdivisions and Operative Statistics in General.

The gliomas comprise the largest group, 862, 42.6 per cent, and naturally merit the greatest consideration; approximately one-half of the book is devoted to gliomas. The original classification of Bailey and Cushing has been reduced to ten subdivisions, some few of which are so rare as to be surgical curiosities. As tumors are being restudied they are constantly being shifted from one division to another so the table of incidence is in a state of flux. Even with the simplification which has taken place the clinical problem remains for there is little clinical difference between an ependyoma and an ependymo-blastoma whilst astrocytomas and medulloblastomas act so differently when situated above and below the tentorium as almost to compose two clinical entities although identical histologically. Each subdivision of the glioma group is discussed independently as to its cystology and life history with particular reference to its rate of growth and its tendency to recur. A few short case reports are given as examples of each. An exact diagnosis is of utmost importance as concerns prognosis.

Of the pituitary adenomas there were 360. For many years the author favored the transsphediodal route but in the last years has gradually swung to an approach from above. There is little difference in the mortality statistics of the two routes but he states "there can be no comparison between the exactitude of the two procedures" and bleeding is more easily controlled from above than from below. He confidentally looks forward to a mortality of 1 or 2 per cent.

A word of warning is sounded regarding the craniophryngiomas which "offer the most baffling problem which confronts the neurosurgeon." At present they are practically inoperable. The same plan is followed in the discussion of each group and all chapters contain many valuable hints to surgeons. The mortality statistics are little short of inspiring for they show what may be accomplished by increasing skill and technic.

The amount of information contained in so small a book is positively astounding. Certainly all who are interested in intracranial problems will desire to read this book; having read it they will desire to possess it. The price is five dollars.

GILBERT ANDERSON, M. D.

International Studies on the Relation Between the Private and Official Practice of Medicine, With Special Reference to the Prevention of Disease: Conducted for the Milbank Memorial Fund: By Sir Arthur Newsholme, K. C. B., M. D., F. R. C. P. Vol. III. Baltimore, Williams & Wilkins Co. 1931. pp. 558.

This volume of the series covers the practice of official and private medicine in England and Wales, Scotland and Ireland.

Sir Arthur continues to give his exhaustive studies in his own interesting style and presents us with every phase of medical service in those countries to which we intuitively turn for light on our own medical problems.

The workings of the National Insurance Act in England and Wales in particular is of special interest to us in America, and we find here a comprehensive resume of its application. Sir Arthur presents no evidence of prejudice or bias in himself in discussing his subject, but on the contrary, freely gives of the opinions of others. We are thereby assured that in referring to this work that we have a true exposition of the state of medical practice in those countries.

Everyone interested in State Medicine should read this and the preceding volumes. Here are laid down precedents to which we can turn in marking our own future, and whether they be good or bad, we cannot fall back on ignorance as our excuse, with such an available array of facts as Sir Arthur has placed before use.

W. H. PERKINS, M. D.

Psyllium Seed—The Latest Laxative: By Joseph F. Montague, M. D. New York, The Montague Hospital for Intestinal Ailments. 1932. pp. 170.

Horatio Alger's most astute tale pales into anemic insignificance next the colorful romance of the fleawort, or the semen psyllii of the psyllium plantago plant. Respendent, triumphant, has been its rise from a weed to the most fashionable of present day carthartics. Formerly grown wild in the field of provincial France, especially near Avignon, it was regarded with contempt, considered a parasite. The lowliest peasants trampled on the "weeds" that one day would bring wealth to their community, joy to the obstipated.

For several centuries, however, these same peasants have been aware of certain therapeutic uses for psyllium seed. They believed it to be "emollient, soothing, relaxing, etc., useful in combating inflammation, facilitating the excretion of urine, intestinal evacuation and the control of all conditions where there is heat, irritation, spasm." But the path to glory is long and the climb to fame is steep and filled with obstacles so it was many years before the virtue of psyllium seed as a carthartic par excellence was universally recognized. Because the seeds are small, smooth, slippery, of a shining brown color, of an oblong shape, someone fancied a resemblance to fleas, hence the name. This verminous appellation proved to be a tremendous obstacle. Who wanted to eat anything that resembled and reminded one of fleas, complained the eternally aesthetic French. The name "graines de longue vie" was then applied in an attempt to counteract the objection. Gradual was the rise to universal fame and popularity but in 1916 or thereabouts the knowledge of the virtue of psyllium began to spread like wild fire. Like France, Germany, India, Spain, England and Italy began to cultivate the plantago plant and "the rest is history." When France began to export the seed to America the demand exceeded the supply. The industry of psyllium cultivation reached its commercial Utopia. In Provence in 1916, 178 pounds of the seed were marketed. In 1931, 1,763,696 pounds were marketed. Prosperity smiled on Provence and Avignon and the surrounding districts. The fleawort was sitting on the top of the world.

How many precious subplots must there be to this romance—peasant families traditionally impoverished become suddenly affluent; rural communities basking in the shadow of the Alps, villages slumbering in innocuous desuetude become suddenly alive with bartering agents leasing lands, bidding for a product formerly useless; the triumph of human labor over the machine age (psyllium requires hand cultivation)—Oh what a story Floyd Gibbons could have made of it!

The superiority of psyllium seed rests in the following claims. It has the bulk-giving qualities of bran without the undesirable irritative effect upon the intestinal mucosa and the danger of fecal impaction. When ingested with proper amounts of water psyllium seed swells and increases the size of the fecal mass, gives off freely its mucilaginous substance which has lubricating properties fully equal to oil, with none of oil's dis-

advantages (leakage, seepage). Unlike oil and bran it is digestible; *i. e.*, it is acted upon by digestives enzymes thus becoming an integral part of the fecal mass instead of surrounding it as does oil.

Winchellesque is the dedication:

To the Universal Ailment—Constipation.
To the Universal Habit—Taking Laxatives.
To the Universal Victim—You and you and you.

MAURICE SULLIVAN, M. D.

Italian Medicine: By Arturo Castiglioni. New York, Paul B. Hoeber, Inc. 1932. pp. 134. (Clio Medica, Vol. 6.)

The development of Italian medicine begins with the great schools of Southern Italy, especially that of Empedocles of Agrigentum in the 5th century B. C. Born of the first philosophic school of Greece, it originated the doctrine of humoral theory and critical days which later dominated Hippocratic medicine. Greatly influenced by the Greeks were the Romans, but in turn the Romans codified in systematic fashion the Greek doctrines, adopted hygienic legislation based on Egyptian and Babylonian regulations and finally made of the profession of a special class. Doctors ranked as high dignitaries in the empire. With the advent of Christianity medicine lost its important place. "It withdrew into the shadow of the church and became under Christian dominance a dogmatic medicine in which the first and most important point was faith."

Italian medicine, as such, had its real beginning in the 10th century. Typical of Italian thought at that time were their tendency to free themselves from scholastic dogmatism, their passion for classical studies and experimental research, and the orientation and regulation of medical study. Salerno and Monte Cassino flouished, influenced by Greek wisdom, but likewise still preserving the Latin influence. The yoke of ecclesiastical laws was thrown off and lay characteristics prevailed in both schools. During the 13th century there was an unending struggle between scholastic medicine and new ideas. The birth of the plastic and graphic arts popularized the necessity of the study of the body, furthered anatomy's cause. In the 15th century Italy became the center of anatomy and the general study of medicine. Galileo's discoveries had made research assume more direction for the experimental sciences. The 16th century found Italy apathetic to the adoption of closed, rigid systems and mysticism and the two centuries that followed were characterized by the birth of sound reasoning headed fast toward clinical medicine. In the past two centuries Italy achieved its present enviable degree of perfection.

Long is Italy's list of medico immortals. Prominently mentioned herein are the following; Burgognome, first to apply antiseptics to infected wounds (he used wine) first to employ an anesthetic in general surgery (he used narcotic soaked sponges); Leonarda da Vinci and Michaelangelo, exponents of plastic and graphic arts, should be included; Vesalius, whom Portal calls "the greatest of all heroes;" Falloppio and Eustacchia, discoverers each of tubes; Benivieni, Ingrassia, Colombo, Aranzia, pathological anatomy artists; Fracastorius, author of "Syphiles sive Morbus Gallicus"; Malphighi, founder of histology; Ramazzini, founder of professional hygiene; Morgagni, father of modern pathology; Scarpa, anatomist of triangle fame; Spallanzani, noted physiologist who made important observations on fecundation (in frogs); Chiarugo, first to reform the care of psychiatric patients; Flaiani, co-discoverer of exophthalmic goitre; Casanova, king of charlatans; Rolando, neuro-anatomist; Rusconi, embryologist who studied the process of segmentation; Golgi, famed histologist; Vassale, wh o described the cause of pancreatic diabetes; Grassi, first to demonstrate the life cycle of the malaria plasmodia; Castellani, who insolated the organism of sleeping sickness; Forlanine, who first proposed artificial pneumothorax for pulmonary tuberculosis; Porro, exponent of Cesarean section and uterine amputation; Ducrey, who discovered the streptococcus of venereal ulcers; Castiglioni and Capparoni, famous historians, and many others.

The author of this primer of Italian medicine is Auturo Castiglioni of the Royal University in Padua. It is translated by resourceful Dr. Krumbhaar, whose versatility apparently knows no bounds. What a pity it is that Dr. Krumbhaar restrained himself from including more of his splendid footnotes. Priceless note: "If, as some think, Fracastorious used this spelling (syphilis) for Ovid's Sipylus, the son of Niobe, we have one of the most eminent medical writers of the Renaissance gliding to immortality on a barbarism."

MAURICE SULLIVAN, M. D.

PUBLICATIONS RECEIVED.

The William & Wilkins Company, Baltimore: Primary Carcinoma of the Lung, by B. M. Fried, M. D. Microscopic Slide Precipitation Tests for the Diagnosis and Exclusion of Syphilis, by B. S. Kline, A. B., M. D.

Paul B. Hoeber, Inc., New York: Practical Treatment of Skin Diseases, by Edward Ahlswede, M. D.

Harvard University Press, Cambridge: The Youngest of the Family, by Joseph Garland, M. D.

J. W. Stacey, Inc., San Francisco: California's Medical Story, by Henry Harris, M. D.

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